4 EVER LIFE INSURANCE COMPANY
Oakbrook Terrace, Illinois 60181

Administrative Office:
GeoBlue®
c/o Worldwide Insurance Services, LLC
933 First Avenue
King of Prussia, PA 19406

Helmerich & Payne Management, LLC

Blue Cross Blue Shield Global Expat

Certificate of Coverage Number: 4EL-9275-23

Effective Date: June 1, 2023

Policy Year: June 1, 2023 to May 31, 2024

This Certificate of Coverage describes the main features of the insurance. It does not waive or alter any of the terms of the Policy(s). If questions arise, the Policy(s) will govern. The Certificate is issued by 4 Ever Life Insurance Company through a Policy issued to the HTH International Group Insurance Trust.

PRESIDENT SECRETARY

Table of Contents

I. Explanation of Terms

You will find terms starting with capital letters throughout Your Certificate of Coverage ("Certificate"). To help You understand Your benefits, most of these terms are defined in the Definitions section of Your Certificate.

This Certificate, and any attached riders, is issued by 4 Ever Life Insurance Company ("Insurer") through a Policy issued to the HTH Group Insurance Trust (the "Group"). The Insurer will use a third party Administrator to perform certain of its duties on its behalf. The Group and the Participant are hereby notified of the use of Worldwide Insurance Services, LLC as its Administrator.

4 Ever Life Insurance Company and Worldwide Insurance Services, LLC are Independent Licensees of the Blue Cross Blue Shield Association.

The benefits, limitations, exclusions and other coverage provisions in this Certificate are subject to the terms of Our Policy with the Group. This Certificate, and any attached riders, are a part of that Policy, which is on file in the Group's office and at Worldwide Insurance Services, LLC. This Certificate replaces any other benefit Certificate You may have received. The Group has delegated authority to Worldwide Insurance Services to use its expertise and judgment as part of the routine operation of the Plan to reasonably apply the terms of the Policy for making decisions as they apply to specific eligibility, benefits and claims situations. This does not prevent You from exercising rights You may have under applicable state or federal law to appeal, have independent review of Our judgment and decisions, or bring a civil lawsuit challenging any eligibility or claims determinations under the Policy, including the exercise of Our judgment and expertise.

This Plan's benefits and Your Out-of-Pocket expenses depend on the Providers You see. In this section You will find out how the Providers You see can affect this Plan's benefits and Your costs.

This Plan makes available to You sufficient numbers and types of Providers to give You access to all covered services. Our Provider networks include Hospitals, Physicians, and a variety of other types of Providers.

This Plan does not require use or selection of a Primary Care Physician, or require referrals for specialty care. Covered Persons may self-refer to Providers, including obstetricians, gynecologists and pediatricians, to receive care, and may do so without prior authorization.

Coverage Area
Benefits under this insurance are available in the following locations:

- Any country outside of the United States, including the eligible Participant's Home Country
- Inside the United States

Note: whenever coverage provided under this Plan would be in violation of any U.S. economic or trade sanctions, such coverage shall be null and void.

BlueCard® Program and Other Inter-Plan Arrangements

4 Ever Life Insurance Company and GeoBlue have relationships with other Blue Cross and/or Blue Shield Licensees generally called "Inter-Plan Arrangements." They include "the BlueCard Program" and arrangements for payments to Non-Participating Providers. Whenever You obtain healthcare services the claims are processed through one of these arrangements. You can take advantage of the BlueCard Program when You receive covered services from hospitals, doctors, and other Providers that are in the network of the local Blue Cross and/or Blue Shield Licensee, called the "Host Blue" in this section. At times, You may also obtain care from Non-Participating Providers. Our payment calculation/practices in both instances are described below.

It is important to note that receiving services through these Inter-Plan Arrangements does not change covered benefits, benefit levels, or any stated residence requirements of this Plan.

- **Out of Area Services.** We have a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs". Whenever You obtain healthcare services outside of Our service area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard® Program and may include negotiated National Account arrangements available between Us and other Blue Cross and Blue Shield Licensees.

  Typically, when accessing care outside of Our service area, You may obtain care from healthcare Providers that have a contractual agreement (i.e., are "Participating Providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, You may obtain care from Non-Participating healthcare Providers. Our payment practices in both instances are described below.

- **BlueCard® Program.** Under the BlueCard® Program, when You access covered healthcare services within the geographic area served by a Host Blue, We will remain responsible for fulfilling Our contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare Providers.

  Whenever You access covered healthcare services outside of Our service area and the claim is processed through the BlueCard® Program, the amount You pay for covered healthcare services is calculated based on the lower of:
  - The billed covered Charges for Your covered services; or
  - The negotiated price that the Host Blue makes available to Us.

Often, this "negotiated price" will consist of a simple discount which reflects the actual price paid by the Host Blue to Your healthcare Provider. But sometimes it is an estimated price that takes into account special arrangements with Your healthcare Provider or Provider group that may include types of settlements, incentive payments, and other credits or Charges. Occasionally it may be an average price, based on a discount that results in expected average savings for similar types of healthcare Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation or modifications of past pricing for the types of transaction modifications noted above. However such adjustments will not affect the price We use for Your claim because they will not be applied retroactively to claims already paid.

Federal law or the law in a small number of states may require the Host Blue to add a surcharge to the calculation. If any federal law or any state law mandates other liability calculation methods, including a surcharge, We would then calculate Your liability for any covered healthcare services according to applicable law.

- **Non-Participating Health Care Providers**

  Your Liability Calculation. When covered health care services are provided by Non-Participating health care Providers, the amount You pay for such services will generally be based on either the Host Blue's Non-Participating health care Provider local payment or the pricing arrangements required by applicable state law. In these situations, You may be liable for the difference between the amount that the Non-Participating health care Provider bills and the payment We will make for the covered services as set forth in this paragraph.

  Exceptions. In certain situations, We may use other payment bases, such as billed covered Charges, the payment We would make if the health care services had been obtained within Our network, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount We will pay for services rendered by Non-Participating health care Providers. In these situations, You may be liable for the difference between the amount that the Non-Participating health care Provider bills and the payment We will make for the covered services as set forth in this paragraph.

  If You obtain services in a state with more than one Blue Plan network, an exclusive network arrangement may be in place. If You see a Provider who is not part of an exclusive network arrangement, that Provider's services will be considered Non-Participating Provider care, and You may be billed the difference between the charge and the maximum allowable amount. You may call the customer service number on Your ID card or go to www.geo-blue.com for more information about such arrangements.

Providers available to You through the BlueCard Program have not entered into contracts with 4 Ever Life Insurance Company. If You have any questions or complaints about the BlueCard Program, please call Us at the customer service telephone number listed on Your ID card.

We, or Our authorized Administrator, will provide written notice to the insured Participant within a reasonable period of time of any Participating Provider's termination or breach of, or inability to perform under, any Provider contract, if We determine that the insured Participant or his/her insured Dependents may be materially and adversely affected, and provide the insured Participant with a current list of Participating Providers.

If the insured Participant needs a new Provider listing for any other reason, he/she may call the customer service telephone number listed on the ID card or go to www.geo-blue.com for a new Provider listing.

International/Foreign Country Providers

If You are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands, Covered Expenses for these Foreign Country Providers are based on the Maximum Reimbursable Charge, if applicable, which may be less than actual billed Charges. Foreign Country Providers can bill the Covered Person for amounts exceeding Covered Expenses. GeoBlue provides a list to Covered Persons of Foreign Country Providers with whom GeoBlue has contracted to accept assignment of claims and direct payments from Us or Our Administrator for Covered Expenses incurred by Covered Persons, thus alleviating the necessity of the Covered Person paying the Foreign Country Provider and submitting a claim for reimbursement. This particular group of Foreign Country Providers are not Participating Providers, but rather a group of Foreign Country Providers for whom GeoBlue is able to provide background information and to arrange access for Covered Persons.

Special Plan Provisions

Services Available in Conjunction With Your Medical Plan

The following pages describe helpful services available in conjunction with Your medical Plan. You can access these services by calling the toll-free number shown on the back of Your ID card.

Case Management
Case Management is a service provided through a Review Organization, which assists individuals with treatment needs that extend beyond the acute care setting. The goal of Case Management is to ensure that patients receive appropriate care in the most effective setting possible whether at home, as an Outpatient, or an Inpatient in a Hospital or specialized facility. Should the need for Case Management arise, a Case Management professional will work closely with the patient, his or her family and the attending Physician to determine appropriate treatment options which will best meet the patient's needs and keep costs manageable. The Case Manager will help coordinate the treatment program and arrange for necessary resources. Case Managers are also available to answer questions and provide ongoing support for the family in times of medical crisis.

Case Managers are Registered Nurses (RNs) and other credentialed health care professionals, each trained in a clinical specialty area such as trauma, high risk pregnancy and neonates, oncology, Mental Health, rehabilitation or general medicine and surgery. A Case Manager trained in the appropriate clinical specialty area will be assigned to You or Your Dependent. In addition, Case Managers are supported by a panel of Physician advisors who offer guidance on up-to-date treatment programs and medical technology. While the Case Manager recommends alternate treatment programs and helps coordinate needed resources, the patient's attending Physician remains responsible for the actual medical care.

- You, Your Dependent or an attending Physician can request Case Management services by calling the toll-free number shown on Your ID card. In addition, Your Employer, a claim office or a utilization review program (see the PAC/CSR section of Your Certificate) may refer an individual for Case Management.
- The Review Organization assesses each case to determine whether Case Management is appropriate.
- You or Your Dependent is contacted by an assigned Case Manager who explains in detail how the program works. Participation in the program is voluntary - no penalty or benefit reduction is imposed if You do not wish to participate in Case Management.
- Following an initial assessment, the Case Manager works with You, Your family and Physician to determine the needs of the patient and to identify what alternate treatment programs are available (for example, in-home medical care in lieu of an extended Hospital convalescence). You are not penalized if the alternate treatment program is not followed;
- The Case Manager arranges for alternate treatment services and supplies, as needed (for example, nursing services or a Hospital bed and other Durable Medical Equipment for the home).
- The Case Manager also acts as a liaison between Us, the patient, his or her family and Physician as needed (for example, by helping You to understand a complex medical diagnosis or treatment plan).
- Once the alternate treatment program is in place, the Case Manager continues to manage the case to ensure the treatment program remains appropriate to the patient's needs.

While participation in Case Management is strictly voluntary, Case Management professionals can offer quality, cost-effective treatment alternatives, as well as provide assistance in obtaining needed medical resources and ongoing family support in a time of need.

Certification Requirements and Pre-Authorization

Certification Requirements – U.S. Providers

For You and Your Dependents

Pre-Admission Certification/Continued Stay Review for Hospital Confinement
Pre-Admission Certification (PAC) and Continued Stay Review (CSR) refer to the process used to certify the Medical Necessity and length of a Hospital Confinement when You or Your Dependent require treatment in a Hospital:

- as a registered bed patient, except for 48/96 hour maternity stays;
- for a Partial Hospitalization at a Skilled Nursing Facility, Rehabilitation Hospital and/or Sub-Acute Facility or Residential Treatment Facility.

You or Your Dependent should request PAC prior to any non-emergency treatment in a Hospital described above. In the case of an emergency admission, You should contact the Review Organization within 48 hours after the admission. For an admission due to pregnancy, You should call the Review Organization by the end of the third month of pregnancy. CSR should be requested, prior to the end of the certified length of stay, for continued Hospital Confinement.

Covered Expenses incurred for which benefits would otherwise be payable under this Plan for the Charges listed below will not include any Hospital Charges for treatment listed above for which PAC was requested, but which was not certified as Medically Necessary.

PAC and CSR are performed through a utilization review program by a Review Organization with which 4 Ever Life and its Administrator have contracted.

In any case, those expenses incurred for which payment is excluded by the terms set forth above will not be considered as expenses incurred for the purpose of any other part of this Plan, except for the "Coordination of Benefits" section.

Prior Authorization/Pre-Authorized

The term Prior Authorization means the approval that a Provider must receive from the Review Organization, prior to services being rendered, in order for certain services and benefits to be covered under this Certificate.

Services that require Prior Authorization include, but are not limited to:

- Inpatient Hospital services, except for 48/96 hour maternity stays;
- Inpatient services at any participating Other Health Care Facility;
- residential treatment;
- Outpatient facility services;
- intensive Outpatient programs;
- advanced radiological imaging;
- non-emergency ambulance;
- comprehensive infertility services;
- bariatric surgery;
- transgender services; or
- transplant services.

Retrospective Review

If neither pre-service review, admission review nor continued stay review were performed, We will use retrospective review to determine if a scheduled admission to a Hospital or any surgery at a Hospital or Ambulatory Surgical Center was Medically Necessary. In the event services are determined to be Medically Necessary, benefits will be provided as described in this Plan. If it is determined that a Hospital stay or any other service is not Medically Necessary, the Covered Person is responsible for payment of the Charges for those services.

How To File Your Claim

There's no paperwork for U.S. Participating Provider care. Just show Your identification card and pay Your share of the cost, if any; Your Provider will submit a claim to 4 Ever Life and their Administrator for reimbursement. U.S. Non-Participating Providers and International claims can be submitted by the Provider if the Provider is able and willing to file on Your behalf. If the Provider is not submitting on Your behalf, You must send Your completed claim form and itemized bills to the claims address listed on the claim form.

You may get the required claim form at www.geo-blue.com or from Your Benefit Plan Administrator. All fully completed claim forms and bills should be sent directly to 4 Ever Life in care of their Administrator.

CLAIM REMINDERS

- Be sure to use Your Insurance ID when Your file a claim or when You call the customer service center.
- Your Insurance ID is shown on Your identification card.
- Be sure to follow the instructions listed on the claim form carefully when submitting a claim to the Administrator.

Timely Filing of U.S. Non-Participating Providers & International Claims

4 Ever Life Insurance Company and its Administrator will consider claims for coverage under the Certificate of Coverage when proof of loss (a claim) is submitted within one year (365 days) for U.S. Non-Participating Providers and International benefits after services are rendered. If services are rendered on consecutive days, such as for a Hospital Confinement, the limit will be counted from the last date of service. If claims are not submitted within one year for U.S. Non-Participating Providers and International benefits, the claim will not be considered valid and will be denied.

II. Who is Eligible for Coverage?

This section of Your Certificate describes who is eligible for coverage. We will use Our expertise and judgment to reasonably construe the terms of this Certificate as they apply to Your eligibility for benefits.

Participant Eligibility
To be a Participant under this Plan, You must meet all of the following requirements:
1. You are in a Class of eligible Participants; and
2. You have completed the waiting period; and
3. You pay any required contribution.

Waiting Period
For initial Participant Group: None

For new Participants: None

Classes of eligible Participants
The following Classes of Participants are eligible for this insurance:
1. All Expatriates Participants
2. All Third Country Nationals

"Expatriate" means an eligible Participant who is working or engaged in the conduct of the Group's business outside of the United States for a period of at least 180 days in a consecutive 12 month period that overlaps with the Plan year.

"Third Country National" generally means a Participant who works or is located outside his or her country of citizenship, and outside the Group's country of domicile.

The Participant normally works or is engaged in the Group's business at least 30 hours a week.

Persons for whom coverage is prohibited under applicable law will not be considered eligible under this Plan.

Effective Date of Participant Insurance
You will become insured on the date You elect the insurance by signing an approved payroll deduction or enrollment form, as applicable, but no earlier than the date You become eligible.

You will become insured on Your first day of eligibility, following Your election, if You are in Active Service on that date, or if You are not in Active Service on that date due to Your health status.

Late Entrant – Participant
You are a Late Entrant if:
- You elect the insurance more than 30 days after You become eligible; or
- You again elect the insurance after You cancel Your payroll deduction (if required).

If You do not elect coverage upon becoming eligible or within 30 days of becoming eligible You will be considered a Late Entrant for other than a special enrollment period. You must wait until the Group's next open enrollment period to enroll, except as provided below.

Dependent Insurance

Eligibility for Dependent Insurance
You will become eligible for Dependent insurance on the later of:
- the day You become eligible for Yourself; or
- the day You acquire Your first Dependent.

For Your Dependents to be insured, You will have to pay the required contribution, if any, toward the cost of Dependent Insurance.

Effective Date of Dependent Insurance
Insurance for Your Dependents will become effective on the date You elect it by signing an approved payroll deduction form (if required), but no earlier than the day You become eligible for Dependent Insurance. All of Your Dependents as defined will be included.

Your Dependents will be insured only if You are insured.

Late Entrant – Dependent

- You are a Late Entrant for Dependent Insurance if: You elect the insurance more than 30 days after You become eligible for it; or
- You again elect insurance after You cancel Your payroll deduction (if required).

A Dependent spouse or minor child enrolled within 30 days following a court order of such coverage will not be considered a Late Entrant.

If You do not elect coverage upon becoming eligible for Dependent insurance or within 30 days of becoming eligible for Dependent insurance You will be considered a Late Entrant for other than a special enrollment period, You must wait until the Group's next open enrollment period to enroll, except as provided below.

Exception for Newborns

Any Dependent child born while You are insured will become insured on the date of their birth if You elect Dependent Insurance no later than 31 days after their birth. If You do not elect to insure Your newborn child within such 31 days, coverage for that child will end on the 31st day. No benefits for expenses incurred beyond the 31st day will be payable. Please see the Newborn Care in the Covered Expenses section of this Certificate.

Eligibility for Coverage for Adopted Children

Any child who is adopted by You, including a child who is placed with You for adoption, will be eligible for Dependent Insurance, if otherwise eligible as a Dependent, upon the date of placement with You. A child will be considered placed for adoption when You become legally obligated to support that child, totally or partially, prior to that child's adoption.

If a child placed for adoption is not adopted, all health coverage ceases when the placement ends, and will not be continued.

The provisions in the "Exception for Newborns" section above that describe requirements for enrollment and effective date of insurance will also apply to an adopted child or a child placed with You for adoption.

Special Enrollment Period

You and/or Your Dependent may also be able to enroll during a special enrollment period. A special enrollment period is not available to You and Your Dependents if coverage under the prior Plan was terminated for cause, or because premiums were not paid on a timely basis.

A special enrollment period applies to You and/or Your Dependents when one of the following events occurs:

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage.

A special enrollment period also applies for You and/or Your Dependent who did not enroll during Your initial enrollment period if the following are true:

- You previously declined coverage under the Policy, but You and/or Your Dependent becomes eligible for a premium assistance subsidy under Medicaid or Children's Health Insurance Program (CHIP). Coverage will begin only if We receive the completed enrollment application and any required premium within 60 days of the date of determination of subsidy eligibility.
- You and/or Your Dependent had existing health coverage under another Plan at the time they had an opportunity to enroll during Your initial enrollment period; and
- Coverage under the prior Plan ended because of any of the following:
  - Loss of eligibility (including legal separation, divorce or death).
  - Termination of employment or reduction in hours of employment.
  - The Employer stopped paying the contributions. This is true even if You and/or Your Dependent continues to receive coverage under the prior Plan and to pay the amounts previously paid by the Employer.
  - In the case of COBRA continuation coverage, the coverage ended.
  - You and/or Your Dependent no longer lives or works in an HMO service area if no other benefit option is available.
  - The Plan no longer offers benefits to a class of individuals that include the eligible Participant and/or Dependent.
  - You and/or Your Dependent incurs a claim that would exceed a lifetime limit on all benefits.
  - You and/or Your Dependent loses eligibility under Medicaid or Children's Health Insurance Program (CHIP).

When an event takes place (for example, a birth, marriage or determination of eligibility for state subsidy), coverage begins on the date of the event if We receive the completed enrollment form and any required premium within 31 days of the event unless otherwise noted above.

III. When does Coverage End?

Events That End Coverage

Coverage will end without notice, except as specified under "Medical Benefits Extension," on the last day of the month in which one of these events occurs:

- For the Participant and Dependents when:
  - The Group Policy is terminated;
  - The next monthly premium is not paid when due or within the grace period;
  - The Participant dies or is otherwise no longer eligible as a Participant;
  - In the case of a collectively bargained Plan, the Employer fails to meet the terms of an applicable collective bargaining agreement or to employ Employees covered by a collective bargaining agreement.
- For a spouse when his or her marriage to the Participant is annulled, or when he or she becomes legally separated or divorced from the Participant, or for a domestic partner upon termination of the domestic partnership arrangement.
- For a child when he or she cannot meet the requirements for Dependent coverage shown under the "Who Is Eligible For Coverage?" section.

The Participant must promptly notify the Employer when a Dependent is no longer eligible to be enrolled as a Dependent under this Plan. The Employer must give Us written notice of a Covered Person's termination within 30 days of the date the Employer is notified of such event.

Temporary Layoff or Leave of Absence

If Your Active Service ends due to temporary layoff or leave of absence, Your insurance will be continued until the date the Employer (a) stops paying premium for You; or (b) otherwise cancels Your insurance. However, Your insurance will not be continued for more than 60 days past the date Your Active Service ends.

Injury or Sickness

If Your Active Service ends due to an Injury or Sickness, Your insurance will be continued while You continuously remain Totally Disabled as a result of the Injury or Sickness. However, Your insurance will not continue past the date the Employer stops paying premium for You or otherwise cancels Your insurance.

Policy Termination

No rights are vested under this Plan. Termination of the Group Policy for this Plan completely ends all Covered Persons' coverage and all of our obligations, except as provided under "Medical Benefits Extension"; please see the "How Do I Continue Coverage?" section below.

The Policy is guaranteed renewable. However, this Plan will automatically terminate if premiums are not paid when due; coverage will end on the last day for which payment was made. This Plan may also terminate as indicated below.

The Group may terminate the Group Policy:

- Effective on any premium due date, upon 30 days' advance written notice.
- By rejecting in writing the Policy changes We make after the initial term. The written rejection must reach Us at least 15 days before the changes are to start. The Group Policy will end on the last date for which premiums were paid.

We may terminate the Group Policy, upon 30 days advance written notice to the Group if:

- The Group has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage
- The Group fails to meet the minimum participation or contribution requirements stated in its signed application
- There is a material breach of the Group Policy, other than non-payment
- Changes in or implementation of federal or state laws that no longer permit the continued offering of the Group Policy
- We discontinue this Group Policy, as allowed by law
- We are otherwise permitted to do so by law

Rescissions

A rescission is a discontinuation of coverage with retroactive effect. Coverage may be rescinded because the individual or the person seeking coverage on behalf of the individual commits fraud or makes an intentional misrepresentation of material fact, as prohibited by the terms of the Policy or was no longer eligible for coverage. However, some retroactive cancellations of coverage are not rescissions. Rescissions do not include retroactive cancellations of coverage for failure to pay required premiums or contributions toward the cost of coverage on time. A prospective cancellation of coverage is not a rescission. If an individual's coverage is going to be rescinded, the individual will receive written notice 30 days before the coverage will be cancelled. A rescission will be considered an Adverse Benefit Determination that can be appealed according to the rules described in this Certificate.

Medical Benefits Extension

During Hospital Confinement Upon Policy Cancellation
If the Medical Benefits under this Certificate cease for You or Your Dependent due to cancellation of the Policy (except if the Policy is canceled for nonpayment of premiums) and You or Your Dependent is Confined in a Hospital on that date, Medical Benefits will be paid for Covered Expenses incurred in connection with that Hospital Confinement. However, no benefits will be paid after the earliest of:

- the date You exceed the Maximum Benefit, if any, shown in the Schedule of Benefits;
- the date You are covered for medical benefits under another group plan;
- the date You or Your Dependent is no longer Hospital Confined; or
- 10 days from the date the Policy is canceled.

The terms of this Medical Benefits Extension will not apply to a child born as a result of a pregnancy which exists when Your Medical Benefits cease or Your Dependent's Medical Benefits cease.

Important Information About Your Medical Plan

Details of Your medical benefits are described on the following pages.

IV. Schedule of Benefits

This section of the Certificate explains the types of expenses You must pay for covered services before the benefits of this Plan are provided. To prevent unexpected Out-of-Pocket Expenses, it is important for You to understand what You are responsible for.

Coinsurance
The term Coinsurance means the percentage of Charges for Covered Expenses that a Covered Person is required to pay under the Plan.

Copayments/Deductibles
Copayments, or Copays, are expenses to be paid by You or Your Dependent for covered services. Deductibles are also expenses to be paid by You or Your Dependent. Deductible amounts are separate from and not reduced by Copayments. Copayments and Deductibles are in addition to any Coinsurance. Once the Deductible maximum in the Schedule of Benefits has been reached, You and Your family need not satisfy any further medical Deductible for the rest of that year.

Out-of-Pocket Expenses
Out-of-Pocket Expenses are Covered Expenses incurred for Charges that are not paid by the benefit Plan. The following expenses contribute to the Out-of-Pocket Maximum, and when the Out-of-Pocket Maximum shown in the Schedule of Benefits is reached, they are payable by the benefit Plan at 100%:

- Coinsurance
- Deductible
- Copayments
- Prescription Drug Copayments

The following Out-of-Pocket Expenses and Charges do not contribute to the Out-of-Pocket Maximum, and they are not payable by the benefit Plan at 100% when the Out-of-Pocket Maximum shown in the Schedule of Benefits is reached:

- Provider Charges in excess of the Maximum Reimbursable Charge.
- Non-compliance penalties, if any, for failure to follow any Certification requirements or Pre-Authorization requirements.
- Non-Covered Expenses.
- Premiums or contributions.

Accumulation of Deductibles and Out-of-Pocket Maximums
Deductibles and Out-of-Pocket Maximums will cross-accumulate between U.S. Participating Provider, U.S. Non-Participating Provider and International. All other Plan maximums and service-specific maximums (dollar and occurrence) will also cross-accumulate.

Multiple Surgical Reductions
Multiple and/or bilateral surgical services rendered by the same professional Provider, in the same setting, and on the same date of service will be reviewed subject to auditing criteria. Allowance for the primary procedure is 100%. Allowance for each secondary procedure will be 50%, After Deductible.

Procedures performed in conjunction with the primary surgical procedure considered by Us to be incidental to that primary procedure will not receive additional reimbursement. Incidental procedures are defined as procedures requiring little additional Provider resources and/or are clinically integral to the performance of the primary procedure.

Assistant Surgeon and Co-Surgeon Charges

Assistant Surgeon
The maximum amount payable will be limited to Charges made by an assistant surgeon as specified in 4 Ever Life or its Administrator's reimbursement policies.

Co-Surgeon
The maximum amount payable will be limited to Charges made by Co-Surgeons as specified in 4 Ever Life or its Administrator's reimbursement policies.

Benefit Highlights	International	U.S. Participating Provider	U.S. Non-Participating Provider
Lifetime Maximum	Unlimited	Unlimited	Unlimited
The Percentage of Covered Expenses the Plan Pays	100%	100%	80% of the Maximum Reimbursable Charge
Maximum Reimbursable Charge	Not Applicable	Not Applicable	150% of Medicare Rates
Maximum Reimbursable Charge is determined based on the lesser of the Provider's normal charge for a similar service or supply; or a percentage of Charges made by Providers of such service or supply in the geographic area where the service is received. These Charges are compiled in a database We have selected. **Note:** The Provider may bill You for the difference between the Provider's normal charge and the Maximum Reimbursable Charge, in addition to applicable Deductibles and Coinsurance.			
Policy Year Medical Deductible			
Individual	$0	$500	$1,000
Family Maximum	$0	2 times the individual Deductible	2 times the individual Deductible
Family members meet only their individual Deductible and then their claims will be covered under the Plan Coinsurance; if the family Deductible has been met prior to their individual Deductible being met, their claims will be paid at the Plan Coinsurance.			
Out-of-Pocket Maximum			
Individual	$0	$1,000	$2,000
Family Maximum	$0	2 times the individual Out-of-Pocket Maximum	2 times the individual Out-of-Pocket Maximum
Family members meet only their individual Out-of-Pocket and then their claims will be covered at 100%; if the family Out-of-Pocket has been met prior to their individual Out-of-Pocket being met, their claims will be paid at 100%.			
Physician's Services			
Physician's Office Visit - Primary Care Physician	100%	100%, No Deductible, $20 Copay	80%, After Deductible
Office Visit – Specialist	100%	100%, No Deductible, $40 Copay	80%, After Deductible
Surgery Performed In the Physician's Office	100%	100%, After Deductible	80%, After Deductible
Second Opinion Consultations (provided on a voluntary basis)	100%	100%, No Deductible, $20 Copay	80%, After Deductible
Allergy Treatment/Injections	100%	100%, No Deductible, $40 Copay	80%, After Deductible
Preventive Care			
Routine Preventive Care – all ages	100% not subject to Plan Deductible or Copayments	100% not subject to Plan Deductible or Copayments	80%, After Deductible
Immunizations – all ages	100% not subject to Plan Deductible or Copayments	100% not subject to Plan Deductible or Copayments	80%, After Deductible
Travel Immunizations	100%	100%, No Deductible	100%, No Deductible
Mammograms, PSA, PAP Smear and Colorectal Cancer Screenings	100% not subject to Plan Deductible or Copayments	100% not subject to Plan Deductible or Copayments	80%, After Deductible
Lead Poisoning Screening Tests For Children under age 6	100% not subject to Plan Deductible or Copayments	100% not subject to Plan Deductible or Copayments	80%, After Deductible

Benefit Highlights	International	U.S. Participating Provider	U.S. Non-Participating Provider
Inpatient Hospital – Facility/Professional Charges			
Bed and Board Charges	100%	100%, After Deductible	80%, After Deductible
Physician's Visits/Consultations	100%	100%, After Deductible	80%, After Deductible
Professional Services (Surgeon, Radiologist, Pathologist, Anesthesiologist)	100%	100%, After Deductible	80%, After Deductible
Inpatient Services at Other Health Care Facilities			
Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities Policy Year Maximum of 120 day limit.	100%	100%, After Deductible	80%, After Deductible
Ambulatory Surgical Services			
Operating Room, Recovery Room, Procedure Room, Treatment Room and Observation Room	100%	100%, After Deductible	80%, After Deductible
Professional Services (Surgeon, Radiologist, Pathologist, Anesthesiologist)	100%	100%, After Deductible	80%, After Deductible
Emergency and Urgent Care Services		If true emergency, the benefit will be paid at the U.S. Participating Provider Rate.	
Hospital Emergency Room	100%	100%, After Deductible, $200 Copay per visit – waived if admitted	80%, After Deductible
Outpatient Professional Services (radiology, pathology and ER Physician)	100%	100%, After Deductible	80%, After Deductible
Urgent Care Facility	100%	100%, After Deductible, $75 Copay	80%, After Deductible
X-ray and/or Lab performed at the Emergency Room or Urgent Care Facility (billed as part of the visit)	100%	100%, After Deductible	80%, After Deductible
X-ray and/or Lab performed at the Independent facility in conjunction with the Emergency Room visit	100%	100%, After Deductible	80%, After Deductible
Ambulance	100%	100%, After Deductible	80%, After Deductible

Benefit Highlights	International	U.S. Participating Provider	U.S. Non-Participating Provider
Laboratory and Radiology Services (includes pre-admission testing)			
Inpatient Facility	100%	100%, After Deductible	80%, After Deductible
Outpatient Facility	100%	100%, After Deductible	80%, After Deductible
Independent X-ray and/or Lab Facility	100%	100%, After Deductible	80%, After Deductible
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans and PET Scans)			
Inpatient Facility	100%	100%, After Deductible	80%, After Deductible
Outpatient Facility	100%	100%, After Deductible	80%, After Deductible
Independent Facility	100%	100%, After Deductible	80%, After Deductible
Maternity Care/Obstetrical Services			
Physician's Office visit to confirm pregnancy	100%	100%, No Deductible, $40 Copay	80%, After Deductible
Global Maternity Fee (Prenatal, Postnatal and Physician's delivery charge)	100%	100%, After Deductible	80%, After Deductible
Physician's Office visits in addition to the global maternity fee	100%	100%, No Deductible, $40 Copay	80%, After Deductible
Laboratory, Radiology Services and or Advance Radiological Imaging	100%	100%, After Deductible	80%, After Deductible
Delivery Charges – Facility (Hospital, Birthing Center)	100%	100%, After Deductible	80%, After Deductible
Services of a Doula In home or facility up to 10 visits (pre and post-natal combined)	100%	Not Covered	Not Covered
Termination of Pregnancy			
Medically Necessary	100%	100%, After Deductible	80%, After Deductible
Elective	100%	100%, After Deductible	80%, After Deductible

Benefit Highlights	International	U.S. Participating Provider	U.S. Non-Participating Provider
Infertility Expenses – Basic Covered Expenses include Charges made by a Physician to diagnose and to surgically treat the underlying medical cause of infertility.			
Physician's Office Visit	100%	100%, No Deductible, $40 Copay	80%, After Deductible
Inpatient Facility	100%	100%, After Deductible	80%, After Deductible
Outpatient Facility	100%	100%, After Deductible	80%, After Deductible
Physician's Services	100%	100%, After Deductible	80%, After Deductible
Infertility Expenses – Comprehensive See benefit description for specific coverages and exclusions. Pre-authorization is required			
Physician's Office Visit	100%	100%, No Deductible, $40 Copay	80%, After Deductible
Outpatient Facility	100%	100%, After Deductible	80%, After Deductible
Physician's Services	100%	100%, After Deductible	80%, After Deductible
Family Planning/Contraception Management See benefit description for specific coverages			
For Women			
Physician's Office Visit	100% not subject to Plan Deductible or Copayments	100% not subject to Plan Deductible or Copayments	80%, After Deductible
Inpatient Facility	100% not subject to Plan Deductible or Copayments	100% not subject to Plan Deductible or Copayments	80%, After Deductible
Outpatient Facility	100% not subject to Plan Deductible or Copayments	100% not subject to Plan Deductible or Copayments	80%, After Deductible
Physician's Services	100% not subject to Plan Deductible or Copayments	100% not subject to Plan Deductible or Copayments	80%, After Deductible
For Men			
Physician's Office Visit	100%	100%, No Deductible, $40 Copay	80%, After Deductible
Inpatient Facility	100%	100%, After Deductible	80%, After Deductible
Outpatient Facility	100%	100%, After Deductible	80%, After Deductible
Physician's Services	100%	100%, After Deductible	80%, After Deductible

Benefit Highlights	International	U.S. Participating Provider	U.S. Non-Participating Provider
Obesity/Bariatric Surgery Subject to Medical Necessity and Clinical guidelines for someone who is Morbidly Obese. Pre-authorization is required			
Physician's Office Visit	100%	100%, No Deductible, $40 Copay	80%, After Deductible
Inpatient Facility	100%	100%, After Deductible	80%, After Deductible
Outpatient Facility	100%	100%, After Deductible	80%, After Deductible
Physician's Services	100%	100%, After Deductible	80%, After Deductible
Organ Transplant Services Includes all medically appropriate, non-Experimental transplants. Pre-authorization is required			
Physician's Office Visit	100%	100%, No Deductible, $40 Copay	80%, After Deductible
Inpatient Facility	100%	100%, After Deductible	80%, After Deductible
Physician's Services	100%	100%, After Deductible	80%, After Deductible
Lifetime Travel Maximum: $10,000 per transplant	100% of Reasonable Expenses	100% of Reasonable Expenses after Plan Deductible	Not covered
Transgender Services See benefit description for covered services. Pre-authorization is required			
Physician's Office Visit	100%	100%, No Deductible, $40 Copay	80%, After Deductible
Inpatient Facility	100%	100%, After Deductible	80%, After Deductible
Outpatient Facility	100%	100%, After Deductible	80%, After Deductible
Physician's Services	100%	100%, After Deductible	80%, After Deductible
Nutritional Evaluation Policy Year Maximum of 3 visit limit. Limit does not apply to treatment of diabetes or for services due to a mental health or substance abuse diagnosis.			
Physician's Office Visit	100%	100%, No Deductible, $40 Copay	80%, After Deductible
Nutritional Formulas	100%	100%, After Deductible	80%, After Deductible
Acupuncture Physician's office visit Policy Year Maximum of 20 visit limit.	100%	100%, No Deductible, $40 Copay	80%, After Deductible

Benefit Highlights	International	U.S. Participating Provider	U.S. Non-Participating Provider
Chiropractic Care/Spinal Manipulations			
Physician's office visit	100%	100%, No Deductible, $40 Copay	80%, After Deductible
Policy Year Maximum of 20 visit limit.			
Telehealth	100%	100%, No Deductible, $20 Copay	80%, After Deductible
Dental Services due to an Injury and Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)			
Limited Benefits – please see the benefit description for limitation on Dental Services due to an Injury			
Physician's Office Visit	100%	100%, No Deductible, $40 Copay	80%, After Deductible
Inpatient Facility	100%	100%, After Deductible	80%, After Deductible
Outpatient Facility	100%	100%, After Deductible	80%, After Deductible
Physician's Services	100%	100%, After Deductible	80%, After Deductible
TMJ Treatment	100%	100%, After Deductible	80%, After Deductible
Diabetic Equipment	100%	100%, After Deductible	80%, After Deductible
Durable Medical Equipment	100%	100%, After Deductible	80%, After Deductible
External Prosthetic Appliances	100%	100%, After Deductible	80%, After Deductible
Wigs (for hair loss due to alopecia areata or cancer treatment) Policy Year Maximum of $500	100%	100%, After Deductible	80%, After Deductible
Mental Health			
Inpatient Facility	100%	100%, After Deductible	80%, After Deductible
Outpatient (Includes Individual, Group and Intensive Outpatient)			
Physician's Office Visit	100%	100%, No Deductible, $20 Copay	80%, After Deductible
Outpatient Facility	100%	100%, After Deductible	80%, After Deductible
Psycho-Educational Testing	100%	100%, After Deductible	80%, After Deductible

Benefit Highlights	International	U.S. Participating Provider	U.S. Non-Participating Provider
Substance Abuse Health			
Inpatient Facility	100%	100%, After Deductible	80%, After Deductible
Outpatient (Includes Individual, Group and Intensive Outpatient)			
Physician's Office Visit	100%	100%, No Deductible, $20 Copay	80%, After Deductible
Outpatient Facility	100%	100%, After Deductible	80%, After Deductible
Hearing Benefit One Examination per 24 month period	100%	100%, No Deductible, $40 Copay	80%, After Deductible
Hearing Aid Benefit Up to $1,000 per hearing aid unit necessary for each hearing impaired ear every 36 months	100%	100%, After Deductible	80%, After Deductible
Home Health Care Services Policy Year Maximum of 120 visit limit.	100%	100%, After Deductible	80%, After Deductible
Private Duty Nursing Policy Year Maximum of 120 visit limit.	100%	100%, After Deductible	80%, After Deductible
Hospice Care Services	100%	100%, After Deductible	80%, After Deductible
Infusion Therapy			
Outpatient Facility	100%	100%, After Deductible	80%, After Deductible
Physician's Services	100%	100%, After Deductible	80%, After Deductible
Short Term Rehabilitative Therapy Policy Year Maximum of 60 visit limit for all therapies combined.			
Physician's Office Visit	100%	100%, No Deductible, $40 Copay	80%, After Deductible
Outpatient Hospital Facility	100%	100%, After Deductible	80%, After Deductible
Note: The Short Term Rehabilitative Therapy maximum does not apply to home health care services, cardiac rehabilitation services or the treatment of autism.			

Prescription Drugs
Schedule of Benefits

The below section describes the coverage for Prescriptions Drugs for You and Your insured Dependents. The Plan provides Prescription Drug benefits for Prescription Drugs and Related Supplies provided by Pharmacies as shown in the Schedule of Benefits and as described in the Prescription Drug Coverage section of this Certificate. To receive Prescription Drug Benefits, You and Your Dependents may be required to pay a portion of the Covered Expenses. That portion includes any applicable Deductible and/or Copayments. Benefits are limited as described in the Prescription Drug section of this Certificate and are subject to the Medical "Exclusions" section of this Certificate.

The following are applicable to all Prescription Drug benefits:

- The Prescription drug designation is as per generally-accepted industry sources and adopted by Us and is subject to change

Prescription Drugs Purchased Outside of the United States	
Retail Pharmacies or Drugs dispensed by a Physician or medical facility on an Outpatient basis – Copayments based on a one (1) month supply	
Tier 1 Prescription Drugs – Generic	0% Copayment per Prescription or refill.
Tier 2 Prescription Drugs – Preferred Brand	0% Copayment per Prescription or refill.
Tier 3 Prescription Drugs – non Preferred Brand	0% Copayment per Prescription or refill.
Mail Order Prescription Drugs using the Insurer's mail order Prescription Drug vendor – Copayments based on a three (3) month supply	
Tier 1 Prescription Drugs – Generic	0% Copayment per Prescription or refill.
Tier 2 Prescription Drugs – Preferred Brand	0% Copayment per Prescription or refill.
Tier 3 Prescription Drugs – non Preferred Brand	0% Copayment per Prescription or refill.

Prescription Drugs Purchased Inside of the United States		
Retail Pharmacies or Drugs dispensed by a Physician or medical facility on an Outpatient basis – Copayments based on a one (1) month supply		
	Participating Retail Pharmacy	**Non Participating Retail Pharmacy**
Tier 1 Prescription Drugs – Generic	$10 Copayment per Prescription or refill. Deductible does not apply.	20% Copayment per Prescription or refill, after Plan Deductible.
Tier 2 Prescription Drugs – Preferred Brand	$20 Copayment per Prescription or refill. Deductible does not apply.	20% Copayment per Prescription or refill, after Plan Deductible.
Tier 3 Prescription Drugs – non Preferred Brand	$30 Copayment per Prescription or refill. Deductible does not apply.	20% Copayment per Prescription or refill, after Plan Deductible.
Mail Order Prescription Drugs using the Insurer's mail order Prescription Drug vendor – Copayments based on a three (3) month supply		
	Participating Provider Mail Order Pharmacy	**Non-Participating Mail Order Pharmacy**
Tier 1 Prescription Drugs – Generic	$30 Copayment per Prescription or refill. Deductible does not apply.	**Not Covered**
Tier 2 Prescription Drugs – Preferred Brand	$60 Copayment per Prescription or refill. Deductible does not apply.	**Not Covered**
Tier 3 Prescription Drugs – non Preferred Brand	$90 Copayment per Prescription or refill. Deductible does not apply.	**Not Covered**

V. Covered Expenses Benefit Description

This section of Your Certificate describes the specific benefits available for covered services. Benefits, subject to the Copayments, coinsurance, Deductibles and limitations as noted are available for a service or supply described in this section when it meets all of these requirements:

- It must be furnished in connection with either the prevention or diagnosis and treatment of a covered Sickness, disease or Injury;
- It must be Medically Necessary (please see the "Definitions" section in this Certificate) and must be furnished in a Medically Necessary setting. Inpatient care is only covered when You require care that could not be provided in an Outpatient setting without adversely affecting Your condition or the quality of care You would receive;
- It must not be excluded from coverage under this Plan;
- The expense for it must be incurred while You are covered under this Plan and after any applicable waiting period required under this Plan is satisfied;
- It must be furnished by a Provider (please see the "Definitions" section in this Certificate) who is performing services within the scope of his or her license or certification;
- It must meet the standards set in Our medical and payment policies. Our medical and payment policies are used to administer the terms of the Plan. Medical policies are generally used to determine if a Covered Person has coverage for a specific procedure or service. Payment policies define billing and Provider payment rules. Our policies are based on accepted clinical practice guidelines and industry standards accepted by organizations like the American Medical Association (AMA).

Benefits for some types of services and supplies may be limited or excluded under this Plan. Please refer to the actual benefit provisions throughout this section and the "Exclusions, Expenses Not Covered and General Limitations" section for a complete description of covered services and supplies, limitations and exclusions. **Any applicable Copayments, Deductibles or limits are shown in the Schedule of Benefits.**

Covered Expenses

- Charges made by a Hospital, on its own behalf, for Bed and Board and other Medically Necessary Services and Supplies; except that for any day of Hospital Confinement, Covered Expenses will not include that portion of Charges for Bed and Board which is more than the Bed and Board Limit shown in the Schedule of Benefits.
- Charges made by a Hospital, on its own behalf, for medical care and treatment received as an Outpatient.
- Charges made by a Free-Standing Surgical Facility, on its own behalf for medical care and treatment.
- Charges made on its own behalf, by an Other Health Care Facility, including a Skilled Nursing Facility, a Rehabilitation Hospital or a subacute facility for medical care and treatment; except that for any day of Other Health Care Facility confinement, Covered Expenses will not include that portion of Charges which are in excess of the Other Health Care Facility Daily Limit shown in the Schedule of Benefits.
- Charges made for Emergency Services and Urgent Care.
- Charges made by a Physician or a Psychologist for professional services.
- Charges made by a Nurse, other than a member of Your family or Your Dependent's family, for professional nursing service.
- Charges made for anesthetics and their administration; diagnostic X-ray and laboratory examinations; X-ray, radium, and radioactive isotope treatment; chemotherapy; blood transfusions; oxygen and other gases and their administration.
- Charges made for laboratory services, radiation therapy and other diagnostic and therapeutic radiological procedures.
- Charges made for family planning, including medical history, physical exam, related laboratory tests, medical supervision in accordance with generally accepted medical practices, other medical services, information and counseling on contraception, implanted/injected contraceptives, after appropriate counseling, medical services connected with surgical therapies (tubal ligations, vasectomies).
- Charges made for the following preventive care services (detailed information is available at www.healthcare.gov):
  - evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
  - immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Covered Person involved;
  - for infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;
  - for women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.
- Charges made for or in connection with mammograms including; a baseline mammogram for asymptomatic women at least age 35; a mammogram every one or two years for a-symptomatic women ages 40-49, but no sooner than two years after a woman's baseline mammogram; an annual mammogram for women age 50 and over; and when prescribed by a Physician, a mammogram, anytime, regardless of the woman's age.
- Charges made for or in connection with travel immunization for Employees and Dependents.
- Surgical or nonsurgical treatment of temporal mandibular joint (TMJ) dysfunction.
- Charges made for or in connection with one baseline lead poison screening test for Dependent children at or around 12 months of age, or in connection with lead poison screening and diagnostic evaluations for Dependent children under the age of 6 years who are at high risk for lead poisoning according to guidelines set by the Department of Health and Human Services.

- Charges made for children from birth through age 18 for immunization against: diphtheria; hepatitis B; measles; mumps; pertussis; polio; rubella; tetanus; varicella; haemophilus influenzae B; and hepatitis A, and any new vaccines recommended by United States Preventive Task Force Services.
- Charges made for U.S. FDA approved prescription contraceptive drugs and devices and for Outpatient contraceptive services including consultations, exams, procedures, and medical services related to the use of contraceptives and devices.
- Charges made for diabetic supplies as recommended in writing or prescribed by a Participating Physician or Other Participating Health Care Professional, including insulin pumps and blood glucose meters.
- Scalp hair prostheses worn due to alopecia areata or due to hair loss resulting from cancer treatment subject to the limits shown in the Schedule of Benefits.
- Colorectal cancer screening for persons 50 years of age or older or those at high risk of colon cancer because of family history of familial adenomatous polyposis; family history of hereditary nonpolyposis colon cancer; chronic inflammatory bowel disease; family history of breast, ovarian, endometrial, colon cancer or polyps; or a background, ethnicity or lifestyle such that the health care Provider treating the Participant or beneficiary believes he or she is at elevated risk. Coverage will include screening with an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in appropriate circumstances radiologic imaging or other screening modalities, provided as determined by the Secretary of Health and Social Services of Delaware after consideration of recommendations of the Delaware Cancer Consortium and the most recently published recommendations established by the American College of Gastroenterology, the American Cancer Society, the United States Preventive Task Force Services, for the ages, family histories and frequencies referenced in such recommendations and deemed appropriate by the attending Physician, Also included is the use of anesthetic agents, including general anesthesia, in connection with colonoscopies and endoscopies performed in accordance with generally-accepted standards of medical practice and all applicable patient safety laws and regulations, if the use of such anesthetic agents is Medically Necessary in the judgment of the treating Physician.
- Hearing aids for Dependent children up to age twenty-six (26).
- Nutritional formulas, low protein modified food products, or other medical food consumed or administered enterally (via tube or orally) which are Medically Necessary for the therapeutic treatment of inherited metabolic diseases, such as phenylketonuria (PKU), maple syrup urine disease, urea cycle disorders, tyrosinemia, and homocystinuria, when administered under the direction of a Physician.
- The treatment of autism spectrum disorder for the following care and assistive communication devices prescribed or ordered for an individual diagnosed with autism spectrum disorder by a licensed Physician or a licensed Psychologist: behavioral health treatment; Pharmacy care; psychiatric care; psychological care; therapeutic care; items and equipment necessary to provide, receive, or advance in the above listed services, including those necessary for applied behavioral analysis; and any care for individuals with autism spectrum disorders that is determined by the Department of Health and Human Services, based upon their review of best practices and/or evidence-based research, to be Medically Necessary.
- Charges made for an annual Papanicolaou laboratory screening test.
- Charges made for an annual prostate-specific antigen test (PSA).
- Charges made for CA-125 monitoring of ovarian cancer subsequent to treatment for ovarian cancer. Coverage is not provided for routine screening.
- Charges for hearing loss screening tests of newborns and infants provided by a Hospital before discharge.

Acupuncture

Benefits for acupuncture services received in a Provider's office when You see a Provider, are subject to the Copay and visit limitations as stated in the Schedule of Benefits. Benefits are provided for acupuncture services when Medically Necessary to relieve pain, induce surgical anesthesia, or to treat a covered Sickness, Injury, or condition.

Ambulance Services

Benefits for the following services are subject to Your Policy Year Deductible and coinsurance.

Benefits are provided for licensed surface (ground or water) and air ambulance transportation to the nearest medical facility equipped to treat Your condition, when any other mode of transportation would endanger Your health or safety. Medically Necessary Services and Supplies provided by the ambulance are also covered. Benefits are also provided for transportation from one medical facility to another, as necessary for Your condition. This benefit only covers the Covered Person that requires transportation.

Breast Reconstruction and Breast Prostheses

Charges made for reconstructive surgery following a mastectomy; benefits include: surgical services for reconstruction of the breast on which surgery was performed; surgical services for reconstruction of the non-diseased breast to produce a symmetrical appearance; postoperative breast prostheses; and mastectomy bras and external prosthetics, limited to the lowest cost alternative available that meets external prosthetic placement needs. During all stages of mastectomy, treatment of physical complications, including lymphedema therapy, are covered.

Chiropractic Care Services/Spinal Manipulations

Charges made for diagnostic and treatment services utilized in an office setting by chiropractic Physicians. Chiropractic treatment includes the conservative management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain, and improve function.

The following limitation applies to Chiropractic Care Services:

- Occupational therapy is provided only for purposes of enabling persons to perform the activities of daily living after an Injury or Sickness.

Chiropractic Care services that are not covered include but are not limited to:

- services of a chiropractor which are not within his scope of practice, as defined by state law;
- Charges for care not provided in an office setting;
- maintenance or treatment consisting of routine, long term or non-Medically Necessary care provided to prevent recurrence or to maintain the patient's current status;
- vitamin therapy.

Clinical Trials

This benefit Plan covers routine patient care costs related to a qualified clinical trial for an individual who meets the following requirements:

(a) is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition; and

(b) either
    - the referring health care professional is a participating health care Provider and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (a); or
    - the individual provides medical and scientific information establishing that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (a).

For purposes of clinical trials, the term "life-threatening disease or condition" means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

The clinical trial must meet the following requirements: The study or investigation must:

- Be approved or funded by any of the agencies or entities authorized by federal law to conduct clinical trials;
- Be conducted under an investigational new drug application reviewed by the Food and Drug Administration; or
- Involve a drug trial that is exempt from having such an investigational new drug application.

Routine patient care costs are costs associated with the provision of health care items and services including drugs, items, devices and services otherwise covered by this benefit Plan for an individual who is not enrolled in a clinical trial and, in addition:

- Services required solely for the provision of the investigational drug, item, device or service;
- Services required for the clinically appropriate monitoring of the investigational drug, device, item or service;
- Services provided for the prevention of complications arising from the provision of the investigational drug, device, item or service;
- Reasonable and necessary care arising from the provision of the investigational drug, device, item or service, including the diagnosis or treatment of complications; and
- Routine patient care costs (as defined) for Covered Persons engaging in clinical trials for treatment of life threatening diseases.

Routine patient care costs do not include:

- The investigational drug, item, device, or service, itself; or
- Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.

If Your Plan includes Participating Providers, clinical trials conducted by Non-Participating Providers will be covered at the Participating Provider benefit level if:

- There are no Participating Providers participating in the clinical trial that are willing to accept the individual as a patient, or
- The clinical trial is conducted outside the individual's state of residence.

Dental Services due to an Injury and Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)

The Plan covers:

- Charges made by a Physician, a Dentist and Hospital for non-surgical treatment of infections or diseases of the mouth, jaw joints or supporting tissues.
- Services and supplies for treatment of, or related conditions of, the teeth, mouth, jaws, jaw joints or supporting tissues (this includes bones, muscles and nerves) for surgery needed to:
    - Treat a fracture, dislocation or wound.
    - Cut out teeth that are partly or completely impacted in the bone of the jaw; teeth that will not erupt through the gum; other teeth that cannot be removed without cutting into bone; the roots of a tooth without removing the entire tooth; cysts, tumors or other diseased tissues.
    - Cut into gums and tissues of the mouth. This is only covered when not done in connection with the removal, replacement or repair of teeth.

  - Alter the jaw, jaw joints or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.
- Hospital services and supplies received for a stay required because of Your condition.
- General anesthesia and related facility services for dental procedures are covered when Medically Necessary for 1 of 3 reasons:
  - Covered Persons who are under 7 years of age;
  - Covered Persons who are developmentally disabled, regardless of age; or
  - Covered Persons whose health is compromised and for whom general anesthesia is Medically Necessary, regardless of age.
- Dental work, surgery and orthodontic treatment needed to remove, repair, restore or reposition:
  - As a result of an Injury to natural teeth damaged, lost or removed; or
  - Other body tissues of the mouth fractured or cut due to Injury.
  - Any such teeth must have been free from decay or in good repair, and be firmly attached to the jaw bone at the time of the Injury.

  If crowns, dentures, bridges or in-mouth appliances are installed due to Injury, Covered Expenses only include Charges for:
  - The first denture or fixed bridgework to replace lost teeth;
  - The first crown needed to repair each damaged tooth; and
  - An in-mouth appliance used in the first course of orthodontic treatment after the Injury.

Please Note: An Injury does not include damage caused by biting or chewing, even if due to a foreign object in food. The treatment must be completed within 12 months of the Injury.

Durable Medical Equipment

Charges made for purchase or rental of Durable Medical Equipment that is ordered or prescribed by a Physician and provided by a vendor approved by Us for use outside a Hospital or Other Health Care Facility. Coverage for repair, replacement or duplicate equipment is provided only when required due to anatomical change and/or reasonable wear and tear. All maintenance and repairs that result from a Covered Person's misuse are the Covered Person's responsibility. Coverage for Durable Medical Equipment is limited to the lowest-cost alternative as determined by the utilization review Physician.

Durable Medical Equipment is defined as items which are designed for and able to withstand repeated use by more than one person; customarily serve a medical purpose; generally are not useful in the absence of Injury or Sickness; are appropriate for use in the home; and are not disposable. Such equipment includes, but is not limited to, crutches, hospital beds, respirators, wheel chairs, and dialysis machines.

Durable Medical Equipment items that are not covered include but are not limited to those that are listed below:
- Bed related Items: bed trays, over the bed tables, bed wedges, pillows, custom bedroom equipment, mattresses, including non-power mattresses, custom mattresses and posturepedic mattresses.
- Bath related Items: bath lifts, non-portable whirlpools, bathtub rails, toilet rails, raised toilet seats, bath benches, bath stools, hand held showers, paraffin baths, bath mats, and spas.
- Chairs, lifts and standing devices: computerized or gyroscopic mobility systems, roll about chairs, geriatric chairs, hip chairs, seat lifts (mechanical or motorized), patient lifts (mechanical or motorized – manual hydraulic lifts are covered if patient is two-person transfer), and auto tilt chairs.
- Special or extra-cost convenience features;
- Structural modifications to Your home or personal vehicle;
- Air quality items: room humidifiers, vaporizers, air purifiers and electrostatic machines.
- Blood/injection related items: blood pressure cuffs, centrifuges, nova pens and needleless injectors.
- Orthopedic appliances prescribed primarily for use during participation in sports, recreation or similar activities;
- Penile prostheses;
- Other equipment: heat lamps, heating pads, cryounits, cryotherapy machines, electronic-controlled therapy units, ultraviolet cabinets, sheepskin pads and boots, postural drainage board, AC/DC adaptors, enuresis alarms, magnetic equipment, scales (baby and adult), stair gliders, elevators, saunas, any exercise equipment and diathermy machines.

External Prosthetic Appliances and Devices

Charges made or ordered by a Physician for: the initial purchase and fitting of external prosthetic appliances and devices available only by prescription which are necessary for the alleviation or correction of Injury, Sickness or congenital defect. Coverage for External Prosthetic Appliances is limited to the most appropriate and cost effective alternative as determined by the utilization review Physician. External prosthetic appliances and devices shall include prostheses/prosthetic appliances and devices, orthoses and orthotic devices; braces; splints; and medical vision hardware.

Prostheses/prosthetic Appliances and Devices

Prostheses/prosthetic appliances and devices are defined as fabricated replacements for missing body parts. Prostheses/prosthetic appliances and devices include, but are not limited to:
- basic limb prostheses;
- terminal devices such as hands or hooks; and
- speech prostheses.

Orthoses and Orthotic Devices
Orthoses and orthotic devices are defined as orthopedic appliances or apparatuses used to support, align, prevent or correct deformities. Coverage is provided for custom foot orthoses and other orthoses as follows:

- Non-foot orthoses – only the following non-foot orthoses are covered:
  - rigid and semi-rigid custom fabricated orthoses;
  - semi-rigid prefabricated and flexible orthoses; and
  - rigid prefabricated orthoses including preparation, fitting and basic additions, such as bars and joints.
- Custom foot orthoses – custom foot orthoses are only covered as follows:
  - for persons with impaired peripheral sensation and/or altered peripheral circulation (e.g. diabetic neuropathy and peripheral vascular disease);
  - when the foot orthosis is an integral part of a leg brace and is necessary for the proper functioning of the brace;
  - when the foot orthosis is for use as a replacement or substitute for missing parts of the foot (e.g. amputated toes) and is necessary for the alleviation or correction of Injury, Sickness or congenital defect; and
  - for persons with neurologic or neuromuscular condition (e.g. cerebral palsy, hemiplegia, spina bifida) producing spasticity, malalignment, or pathological positioning of the foot and there is reasonable expectation of improvement and from foot disfigurement caused by accident or developmental disability

The following are specifically excluded orthoses and orthotic devices:

- prefabricated foot orthoses;
- cranial banding and/or cranial orthoses. Other similar devices are excluded except when used postoperatively for synostotic plagiocephaly. When used for this indication, the cranial orthosis will be subject to the limitations and maximums of the External Prosthetic Appliances and Devices benefit;
- orthosis shoes, shoe additions, procedures for foot orthopedic shoes, shoe modifications and transfers;
- orthoses primarily used for cosmetic rather than functional reasons; and
- orthoses primarily for improved athletic performance or sports participation.

Braces
A Brace is defined as an orthosis or orthopedic appliance that supports or holds in correct position any movable part of the body and that allows for motion of that part.

The following braces are specifically excluded: Copes scoliosis braces.

Splints
A Splint is defined as an appliance for preventing movement of a joint or for the fixation of displaced or movable parts.

Coverage for replacement of external prosthetic appliances and devices is limited to the following:

- Replacement due to regular wear. Replacement for damage due to abuse or misuse by the person will not be covered.
- Replacement will be provided when anatomic change has rendered the external prosthetic appliance or device ineffective. Anatomic change includes significant weight gain or loss, atrophy and/or growth.
- Coverage for replacement is limited as follows:
  - no more than once every 24 months for persons 19 years of age and older;
  - no more than once every 12 months for persons 18 years of age and under; and
  - replacement due to a surgical alteration or revision of the site.

The following are specifically excluded external prosthetic appliances and devices:

- external and internal power enhancements or power controls for prosthetic limbs and terminal devices; and
- Myoelectric prostheses peripheral nerve stimulators.

Medical Vision Hardware
Benefits are provided for vision hardware for the following medical conditions of the eye: corneal ulcer, bullous keratopathy, recurrent erosion of cornea, tear film insufficiency, aphakia, Sjogren's disease, congenital cataract, corneal abrasion and keratoconus.

Family Planning and Contraceptive Management

Benefits for sterilization and for contraceptive management are covered as shown in the Schedule of Benefits. Coverage differences apply to men and women.

This benefit covers the following services and supplies received from a health care Provider:

- Office visits and consultations related to contraception;
- Injectable contraceptives and related services;
- Implantable contraceptives (including hormonal implants) and related services
- Emergency contraception methods (oral or injectable); and
- Sterilization procedures. When sterilization is performed as the secondary procedure, associated services such as anesthesia and facility Charges will be subject to Your cost-shares under the applicable facility benefit and are not covered by this benefit.

Contraceptives Dispensed By a Pharmacy

- Prescription contraceptives (including emergency contraception) and prescription barrier devices or supplies that are dispensed by a licensed Pharmacy are covered under the Prescription Drugs benefit. For women, the normal cost-share is waived for these devices and for generic and single-source brand name birth control drugs when You get them from a Participating Pharmacy.

  Examples of covered devices are diaphragms and cervical caps.

- Over-the-counter female contraceptives that are prescribed by Your healthcare Provider and purchased through a licensed Pharmacy are also covered. No cost-share is required when You get them through a Participating Pharmacy.

The Contraceptive Management and Sterilization benefit does not cover:

- Over-the-counter male contraceptive drugs, supplies or devices;
- Prescription contraceptive take-home drugs dispensed and billed by a Provider's office;
- Hysterectomy. (Covered on the same basis as other surgeries. See the Surgical Services benefit.);
- Sterilization reversal; or
- Testing, diagnosis, and treatment of infertility, including fertility enhancement services, procedures, supplies and drugs

Genetic Testing

Charges made for genetic testing that uses a proven testing method for the identification of genetically-linked inheritable disease. Genetic testing is covered only if:

- A person has symptoms or signs of a genetically-linked inheritable disease;
- It has been determined that a person is at risk for carrier status as supported by existing peer-reviewed, evidence-based, scientific literature for the development of a genetically-linked inheritable disease when the results will impact clinical outcome; or
- The therapeutic purpose is to identify specific genetic mutation that has been demonstrated in the existing peer-reviewed, evidence-based, scientific literature to directly impact treatment options.
- For Pregnancy and Maternity Care - Benefits are provided for participation in the Expanded Alpha Feto Protein (AFP) prenatal testing Program.
- For Prenatal Diagnosis of Genetic Disorders: Benefits are paid for prenatal diagnosis of genetic disorders of the fetus by means of diagnostic procedures in cases of High-risk Pregnancy. High-risk Pregnancy means a pregnancy in which some condition puts the mother, the developing fetus, or both at higher-than-normal risk for complications during or after the pregnancy and birth and must be classified as having one of the following risk factors:
  - Moderate to severe preeclampsia (toxemia);
  - Chronic hypertension;
  - Moderate to severe renal disease;
  - Severe heart disease (class II-IV);
  - Insulin-dependent diabetes;
  - Uterine malformation;
  - Incompetent cervix;
  - Polyhydramnios or oligohydramnios; or
  - Placenta previa.

Pre-implantation genetic testing, genetic diagnosis prior to embryo transfer, is covered when either parent has an inherited disease or is a documented carrier of a genetically-linked inheritable disease.

Genetic counseling is covered if a person is undergoing approved genetic testing, or if a person has an inherited disease and is a potential candidate for genetic testing. Genetic counseling is limited to 5 visits per calendar year for both pre- and post-genetic testing.

Home Health Care Services

Home Health Care must be preauthorized.

Covered Expenses include Charges for Home Health Care Services when ordered by a Physician as part of a home health Plan and provided You are:

- Transitioning from a Hospital or other Inpatient facility, and the services are in lieu of a continued Inpatient stay; or
- Homebound.

Covered Expenses include only the following:

- Skilled nursing services that require medical training of, and are provided by, a licensed nursing professional within the scope of his or her license. These services need to be provided during intermittent visits of four hours or less, with a daily maximum of three visits. Intermittent visits are considered periodic and recurring visits that skilled Nurses make to ensure Your proper care, which means they are not on site for more than four hours at a time. If You are discharged from a Hospital or Skilled Nursing Facility after an Inpatient stay, the intermittent requirement may be waived to allow coverage for up to 12 hours (three visits) of continuous skilled nursing services. However, these services must be provided for within 10 days of discharge.

- Home health aide services, when provided in conjunction with skilled nursing care, that directly support the care. These services need to be provided during intermittent visits of four hours or less, with a daily maximum of three visits.
- Medical social services, when provided in conjunction with skilled nursing care, by a qualified social worker.
- Skilled care is skilled nursing, skilled teaching and skilled rehabilitation services when:
  - It is delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient;
  - It is ordered by a Physician;
  - It is not delivered for the purpose of assisting with activities of daily living, including but not limited to, dressing, feeding, bathing or transferring from a bed to a chair; and
  - It requires clinical training in order to be delivered safely and effectively.
- You are expected to improve to a predictable level of recovery. Benefits can be denied or shortened if You are not progressing in goal-directed rehabilitation services or discharge rehabilitation goals.

Four hours = one visit; the Plan allows up to three visits per date of service (the maximum number of hours per day is 12 hours).

Benefits for Home Health Care visits are payable up to the Home Health Care Maximum shown in the Schedule of Benefits. Each visit by a Nurse or therapist is one visit.

In figuring the maximum visits, each visit of up to four hours is one visit. This maximum will not apply to care given by an R.N. or L.P.N. when:
- Care is provided within 10 days of discharge from a Hospital or Skilled Nursing Facility as a full-time Inpatient; and
- Care is needed to transition from the Hospital or Skilled Nursing Facility to home care.

When the above criteria are not met, Covered Expenses include up to 12 hours of continuous care by an R.N. or L.P.N. per day.

Coverage for Home Health Care Services is not determined by the availability of caregivers to perform them. The absence of a person to perform a non-skilled or Custodial Care service does not cause the service to become covered. If the Covered Person is a minor or an adult who is dependent upon others for non-skilled care (e.g., bathing, eating, toileting), coverage for home health services will only be provided during times when there is a family Covered Person or caregiver present in the home to meet the person's non-skilled needs.

Home Health Care Limits
Unless specified above, not covered under this benefit are Charges for:
- Services or supplies that are not a part of the Home Health Care Plan.
- Services of a person who usually lives with You, or who is a member of Your or Your spouse's or Your domestic partner's family.
- Services of a certified or licensed social worker.
- Services for Infusion Therapy.
- Transportation.
- Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present.
- Services that are Custodial Care.

The Plan does not cover Custodial Care, even if care is provided by a nursing professional, and family members or other caretakers cannot provide the necessary care.

Refer to the Schedule of Benefits for details about any applicable Home Health Care visit maximums.

Benefits for Home Health Care visits are payable up to the Home Health Care Maximum. Each visit by a Nurse or therapist is one visit.

Hospice Care Services

Charges made for a Covered Person who has been diagnosed as having six months or fewer to live, due to Terminal Illness, for the following Hospice Care Services provided under a Hospice Care Program:
- by a Hospice Facility for Bed and Board and Services and Supplies;
- by a Hospice Facility for services provided on an Outpatient basis;
- by a Physician for professional services;
- for pain relief treatment, including drugs, medicines and medical supplies;
- by an Other Health Care Facility for:
  - part-time or intermittent nursing care by or under the supervision of a Nurse;
  - part-time or intermittent services of an Other Health Care Professional;
- physical, occupational and speech therapy;
- medical supplies; drugs and medicines lawfully dispensed only on the written prescription of a Physician; and laboratory services; but only to the extent such Charges would have been payable under this Certificate if the Covered Person had remained or been Confined in a Hospital or Hospice Facility.
- Up to three (3) bereavement sessions, including assessment of the needs of the bereaved family and development of a care Plan to meet those needs, both prior to and following the Covered Person's death. Bereavement services are available to surviving members of the immediate family for a period of one year after the death. Your immediate family means Your spouse, children, stepchildren, parents, and siblings.

The following Charges for Hospice Care Services are not included as Covered Expenses:

- for the services of a person who is a member of Your family or Your Dependent's family or who normally resides in Your house or Your Dependent's house;
- for any period when You or Your Dependent is not under the care of a Physician;
- for services or supplies not listed in the Hospice Care Program;
- for any curative or life-prolonging procedures;
- to the extent that any other benefits are payable for those expenses under this Certificate;
- for services or supplies that are primarily to aid You or Your Dependent in daily living.

Hospital Inpatient Care

Benefits are provided for the following Inpatient medical and surgical services:

- Semi-Private Bed and Board expenses, including general duty nursing and special diets

  Note: When outside the United States, this benefit will provide coverage for private rooms if that is all that is available or if the choice is between a ward or a more than two person room and a private room.

- Use of an intensive care or coronary care unit equipped and operated according to generally recognized Hospital standards.
- Operating room, surgical supplies, Hospital anesthesia services and supplies, drugs, dressings, equipment and oxygen.
- Facility Charges for diagnostic and therapeutic services. Facility Charges include any services received by a Hospital-employed Provider and billed by the Hospital.
- Blood, blood derivatives and their administration.
- Parental Accommodation – if charged by a Hospital, Charges for one parent or legal guardian to stay in a Hospital with a covered child under the age of 12.

For Inpatient Hospital substance abuse treatment, please see the Mental Health and Substance Abuse Services benefit description.

For benefit information on professional diagnostic services done while at the Hospital, see the Diagnostic Services benefit.

This benefit does not cover:

- Hospital admissions for diagnostic purposes only, unless the services cannot be provided without the use of Inpatient Hospital facilities, or unless Your medical condition makes Inpatient care Medically Necessary.
- Any days of Inpatient care that exceeds the length of stay that is Medically Necessary to treat Your condition.

Infertility Services

Basic Infertility Expenses

Covered Expenses include Charges made by a Physician to diagnose and to surgically treat the underlying medical cause of infertility.

Comprehensive Infertility Expenses

To be eligible for benefits You must be covered under the Plan as a Participant or be a covered Dependent who is the Participant's spouse or domestic partner.

Even though not incurred for treatment of a Sickness or Injury, Covered Expenses will include expenses incurred by an eligible covered female for infertility if all of the following tests are met:

- A condition that is a demonstrated cause of infertility that has been recognized by a gynecologist, or an infertility Specialist, and Your Physician who diagnosed You as Infertile, and it has been documented in Your medical records.
- The procedures are done while not confined in a Hospital or any other facility as an Inpatient.
- Your FSH levels are less than 19 miU/ml on day three of the menstrual cycle.
- The infertility is not caused by voluntary sterilization of either one of the partners (with or without surgical reversal) or a hysterectomy.
- A successful pregnancy cannot be attained through less costly treatment for which coverage is available under this Plan.

If You meet the eligibility requirements above and You do not conceive after treatment for the underlying cause of the Infertility, or if the diagnosis indicates that You are not likely to become pregnant after such treatment, You are eligible for additional Infertility services. The Plan covers the following, when approved in advance by the claims Administrator, subject to all the exclusions and limitations of this Certificate:

- Ovulation induction with menotropins is subject to the maximum benefit, if any, shown in Your Schedule of Benefits; and
- Intrauterine insemination is subject to the maximum benefit, if any, shown in Your Schedule of Benefits.

Advanced Reproductive Technology (ART) Benefits
ART is defined as:
- In vitro fertilization (IVF);Zygote intrafallopian transfer (ZIFT);
- Gamete intra-fallopian transfer (GIFT);
- Cryopreserved embryo transfers; and
- Intracytoplasmic sperm injection (ICSI); or
- ovum microsurgery.

To be eligible for ART benefits under this Plan, You must meet the requirements above and:
- First exhaust the comprehensive infertility services benefits. Coverage for ART services is available only if comprehensive infertility services do not result in a pregnancy in which a fetal heartbeat is detected;
- Be referred by Your Physician to claims Administrator's Infertility case management unit;
- Obtain pre-authorization from the claims Administrator's Infertility case management unit for ART services by an ART Specialist.

Covered ART Benefits
The following Charges are covered benefits for eligible covered females when all of the above conditions are met and the services are performed on an Outpatient basis, subject to the Medical Plan Exclusions section of the booklet:
- Up to three cycles and subject to the maximum benefit, if any, shown in Your Schedule of Benefits of any combination of the following ART services per lifetime (where lifetime is defined to include all ART services received) which only include: IVF; GIFT; ZIFT or cryopreserved embryo transfers;
- In vitro fertilization (IVF); intracytoplasmic sperm injection (ICSI); ovum microsurgery; GIFT; ZIFT or cryopreserved embryo transfers subject to the maximum benefit shown in Your Schedule of Benefits while covered under the Plan;
- Payment for Charges associated with the care of an eligible Covered Person under this Plan who is participating in a donor IVF program, including fertilization and culture; and
- Charges associated with obtaining the spouse's or domestic partner's sperm for ART, when the spouse or domestic partner is also covered under this Plan.

For all Outpatient expenses arising from in vitro fertilization procedures performed on You or Your Covered Dependent spouse to the same extent as the benefits provided for other pregnancy-related procedures if:
- the patient is the Covered Person or a Covered Dependent spouse;
- the patient's oocytes are fertilized with the patient's spouse's sperm, unless:
  - the patient's spouse is unable to produce and deliver functional sperm; and
  - the inability to produce and deliver functional sperm does not result from (i) a vasectomy; or (ii) another method of voluntary sterilization;
- if the patient and the patient's spouse are of the same sex, six attempts of artificial insemination over the course of 2 years fails to result in pregnancy;
- the patient and the patient's spouse have a history of infertility of at least two (2) years duration including any pregnancy of the patient that terminates as the result of a miscarriage; or the infertility is associated any of the following medical conditions:
  - endometriosis;
  - exposure in utero to diethylstilbestrol, commonly known as DES;
  - blockage of, or surgical removal of, one or both fallopian tubes (lateral or bilateral salpingectomy); or
  - abnormal male factors, including oligospermia, contributing to the infertility;
- the patient has been unable to attain a successful pregnancy through a less costly infertility treatment for which coverage is available under the Certificate; and
- the in-vitro fertilization procedures are performed at medical facilities that conform to applicable guidelines or minimum standards issued by the American College of Obstetricians and Gynecologists or the American Society for Reproductive Medicine.

Infertility Exclusions and Limitations
Unless otherwise specified above, the following Charges will not be payable as Covered Expenses under this Plan:
- ART services for a female attempting to become pregnant who has not had at least one year or more of timed, unprotected coitus, or 12 cycles of artificial insemination (for covered persons under 35 years of age), or six months or more of timed, unprotected coitus, or six cycles of artificial insemination (for covered persons 35 years of age or older) prior to enrolling in the infertility program;
- ART services for couples in which one of the partners has had a previous sterilization procedure, with or without surgical reversal;
- Reversal of sterilization surgery;
- Infertility services for females with FSH levels 19 or greater mIU/ml on day three of the menstrual cycle;
- The purchase of donor sperm and any Charges for the storage of sperm; the purchase of donor eggs and any Charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers (or surrogacy); all Charges associated with a gestational carrier program for the covered person or the gestational carrier;
- Charges associated with cryopreservation or storage of cryopreserved eggs and embryos (e.g., office, Hospital, ultrasounds, laboratory tests, etc.);
- Home ovulation prediction kits;
- Drugs related to the treatment of non-covered benefits;

- Injectable infertility medications, including but not limited to, menotropins, hCG, GnRH agonists, and IVIG;
- Any services or supplies provided without pre-authorization from claims Administrator's infertility case management unit;
- Infertility Services that are not reasonably likely to result in success; or
- Ovulation induction and intrauterine insemination services if You are not Infertile.

These exclusions apply to ART services other than in-vitro fertilization coverage.

Treatment of Infertility must be pre-authorized. Treatment received without pre-authorization will not be covered. You will be responsible for full payment of the services. Refer to Your Schedule of Benefits for details about the maximums that apply to infertility services.

Infusion Therapy

Covered Expenses include Charges made on an Outpatient basis for Infusion Therapy if the rendering Provider's bill includes fees for both medication and administration and if the services are provided by:

- A free-standing facility;
- The Outpatient department of a Hospital; or
- A Physician in his/her office or in Your home.

When You obtain Infusion Therapy medications from a Pharmacy or if they are not billed by Your Provider along with the therapy administration fee, You should submit Your claims for medications under the Prescription Drug benefits, rather than the medical benefits.

Infusion Therapy is the intravenous or continuous administration of medications or solutions that are a part of Your course of treatment. Charges for the following Outpatient Infusion Therapy services and supplies are Covered Expenses:

- The pharmaceutical when administered in connection with Infusion Therapy and any medical supplies, equipment and nursing services required to support the infusion therapy;
- Professional services;
- Total parenteral nutrition (TPN);
- Chemotherapy;
- Drug therapy (includes antibiotic and antivirals);
- Pain management (narcotics); and
- Hydration therapy (includes fluids, electrolytes and other additives).

Not included under this Infusion Therapy benefit are Charges incurred for:

- Enteral nutrition;
- Blood transfusions and blood products;
- Dialysis; and
- Insulin.

Coverage for Inpatient Infusion Therapy is provided under the Plan's Inpatient Hospital and Skilled Nursing Facility benefits.

Benefits payable for Infusion Therapy will not count toward any applicable Home Health Care maximums.

Internal Prosthetic/Medical Appliances

Charges made for internal prosthetic/medical appliances that provide permanent or temporary internal functional supports for nonfunctional body parts are covered. Medically Necessary repair, maintenance or replacement of a covered appliance is also covered.

Maternity Care/Obstetrical Services

Benefits for pregnancy and childbirth are provided on the same basis as any other condition for the Participant or enrolled spouse or enrolled Dependent child. Complications of pregnancy are covered on the same basis as any other Sickness for the Participant, enrolled spouse, or enrolled Dependent child.

Preventive diagnostic services that meet the guidelines for preventive care are covered for all eligible Covered Persons as stated in the Preventive Care benefit.

Inpatient Hospital Services

Benefits for these services are shown in the Schedule of Benefits.

Birthing Center and Short-Stay Hospital Facility Services

Benefits for these services are shown in the Schedule of Benefits.

This benefit covers Inpatient Hospital, birthing center, Outpatient Hospital and emergency room services, including post-delivery care as determined necessary by the attending Provider, in consultation with the mother, based on accepted medical practice.

Group health Plans and health insurance issuers generally may not, under federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section.

However, this restriction does not apply in any case where the decision to discharge the mother or her newborn child before the expiration of the minimum length of stay is made by an attending Provider in consultation with the mother.

Plan benefits are also provided for Medically Necessary supplies related to home births.

Benefits for the following obstetrical care services are covered as shown in the Schedule of Benefits.

- Prenatal care, including diagnostic and screening procedures, and genetic counseling for prenatal diagnosis of congenital disorders of the fetus. For genetic screen specifics, please see the Genetic Testing benefit described in this Certificate.
- Delivery, including cesarean section, in a medical facility, or delivery in the home.
- Postpartum care consistent with accepted medical practice that's ordered by the attending Provider, in consultation with the mother. Postpartum care includes services of the attending Provider, a home health agency and/or registered Nurse.
- Coverage for a Doula (a trained birth assistant) services in home or facility up to 10 visits (pre and post-natal combined).

Attending Provider as used in this benefit means a Physician (M.D. or D.O.), a Physician's assistant, a certified Nurse midwife (C.N.M.), a licensed midwife or an advanced registered Nurse practitioner (A.R.N.P.). If the attending Provider bills a global fee that includes prenatal, delivery and/or postpartum services received on multiple dates of service, this Plan will cover those services as it would any other surgery. Please see the Schedule of Benefits for details.

Mental Health and Substance Abuse Services

Mental Health Services are services that are required to treat a disorder that impairs the behavior, emotional reaction or thought processes. In determining benefits payable, Charges made for the treatment of any physiological conditions related to Mental Health will not be considered to be Charges made for treatment of Mental Health.

Substance Abuse is defined as the psychological or physical dependence on alcohol or other mind-altering drugs that requires diagnosis, care, and treatment. In determining benefits payable, Charges made for the treatment of any physiological conditions related to rehabilitation services for alcohol or drug abuse or addiction will not be considered to be Charges made for treatment of Substance Abuse.

Inpatient Mental Health Services
Services that are provided by a Hospital while You or Your Dependent is confined in a Hospital for the treatment and evaluation of Mental Health. Inpatient Mental Health Services include Partial Hospitalization and Mental Health Residential Treatment Services.

Partial Hospitalization sessions are services that are provided for not less than 4 hours and not more than 12 hours in any 24- hour period.

Mental Health Residential Treatment Services are services provided by a Hospital for the evaluation and treatment of the psychological and social functional disturbances that are a result of subacute Mental Health conditions.

Mental Health Residential Treatment Center means an institution which specializes in the treatment of psychological and social disturbances that are the result of Mental Health conditions; provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians; provides 24-hour care, in which a person lives in an open setting; and is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.

A person is considered confined in a Mental Health Residential Treatment Center when she/he is a registered bed patient in a Mental Health Residential Treatment Center upon the recommendation of a Physician.

Outpatient Mental Health Services
Services of Providers who are qualified to treat Mental Health when treatment is provided on an Outpatient basis, while You or Your Dependent is not confined in a Hospital, and is provided in an individual, group or Mental Health Intensive Outpatient Therapy Program. Covered services include, but are not limited to, Outpatient treatment of conditions such as: anxiety or depression which interfere with daily functioning; emotional adjustment or concerns related to chronic conditions, such as psychosis or depression; emotional reactions associated with marital problems or divorce; child/adolescent problems of conduct or poor impulse control; affective disorders; suicidal or homicidal threats or acts; eating disorders; or acute exacerbation of chronic Mental Health conditions (crisis intervention and relapse prevention) and Outpatient testing and assessment.

A Mental Health Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed Mental Health program. Intensive Outpatient Therapy Programs provide a combination of individual, family and/or group therapy in a day, totaling nine or more hours in a week.

Inpatient Substance Abuse Rehabilitation Services
Services provided for rehabilitation, while You or Your Dependent is confined in a Hospital, when required for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs. Inpatient Substance Abuse Services include Partial Hospitalization sessions and Residential Treatment services.

Partial Hospitalization sessions are services that are provided for not less than 4 hours and not more than 12 hours in any 24- hour period.

Substance Abuse Residential Treatment Services are services provided by a Hospital for the evaluation and treatment of the psychological and social functional disturbances that are a result of subacute Substance Abuse conditions.

Substance Abuse Residential Treatment Center means an institution which specializes in the treatment of psychological and social disturbances that are the result of Substance Abuse; provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians; provides 24- hour care, in which a person lives in an open setting; and is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.

A person is considered confined in a Substance Abuse Residential Treatment Center when she/he is a registered bed patient in a Substance Abuse Residential Treatment Center upon the recommendation of a Physician.

Outpatient Substance Abuse Rehabilitation Services
Services provided for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs, while You or Your Dependent is not confined in a Hospital, including Outpatient rehabilitation in an individual, a group, or a Substance Abuse Intensive Outpatient Therapy Program.

A Substance Abuse Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed Substance Abuse program. Intensive Outpatient Therapy Programs provide a combination of individual, family and/or group therapy in a day, totaling nine, or more hours in a week.

Substance Abuse Detoxification Services
Detoxification and related medical ancillary services are provided when required for the diagnosis and treatment of addiction to alcohol and/or drugs. We will decide, based on the Medical Necessity of each situation, whether such services will be provided in an Inpatient or Outpatient setting.

Exclusions
The following are specifically excluded from Mental Health and Substance Abuse Services:

- Treatment of disorders which have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain.
- Developmental disorders, including but not limited to, developmental reading disorders, developmental arithmetic disorders, developmental language disorders or developmental articulation disorders.
- Counseling for activities of an educational nature; for borderline intellectual functioning; occupational problems; counseling related to consciousness raising; and for vocational or religious counseling.
- Any costs associated with voluntary support groups, such as Alanon or Alcoholics Anonymous.
- I.Q. testing.
- Custodial Care, including but not limited to geriatric day care, and halfway houses, quaterway houses, recovery houses, and other sober living residences.
- Occupational/recreational therapy programs even if combined with supportive therapy for age-related cognitive decline.

Newborn Care

Newborn children are covered automatically for the first 31 days from birth when the mother is eligible to receive obstetrical care benefits under this Plan. To continue benefits beyond the 31 day period, please see the Dependent eligibility and enrollment guidelines outlined in the "Who Is Eligible For Coverage?" and "When Does Coverage Begin?" sections.

If the mother is not eligible to receive obstetrical care benefits under this Plan, the newborn is not automatically covered for the first 31 days. For newborn enrollment information, please see the "Who Is Eligible For Coverage?" section.

Plan benefits and provisions will apply, subject to the child's own applicable Copay, Policy Year Deductible and coinsurance requirements, and may include the services listed below. Services must be consistent with accepted medical practice and ordered by the attending Provider in consultation with the mother.

Hospital Care
Benefits for these services are subject to Your Policy Year Deductible and coinsurance when You use a facility.

The Newborn Care benefit covers Hospital nursery care as determined necessary by the attending Provider, in consultation with the mother, based on accepted medical practice. Also covered are any required readmissions to a Hospital and Outpatient or emergency room services for Medically Necessary treatment of a Sickness or Injury.

Group health Plans and health insurance issuers generally may not, under federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, this restriction does not apply in any case where the decision to discharge the mother or her newborn child before the expiration of the minimum length of stay is made by an attending Provider in consultation with the mother.

Professional Care
Benefits for services received in a Provider's office are subject to the terms of the Professional Visit benefit. Well-baby exams in the Provider's office are covered under the Preventive Care benefit. This benefit covers:

- Inpatient newborn care, including newborn exams
- Follow-up care consistent with accepted medical practice that is ordered by the attending Provider, in consultation with the mother. Follow-up care includes services of the attending Provider, a home health agency and/or a registered Nurse.
- Circumcision

Inpatient Professional Care
Benefits for these services are subject to Your Policy Year Deductible and coinsurance when services are provided by an attending Provider.

Outpatient Professional Visits
You pay the Copay as stated in the Schedule of Benefits per visit in an office setting when You use a Provider.

When You see a Provider outside an office setting, benefits are subject to Your Policy Year Deductible and coinsurance.

Please Note: Attending Provider as used in this benefit means a Physician (M.D. or D.O.), a Physician's assistant, a certified Nurse midwife (C.N.M.), a licensed midwife or an advanced registered Nurse practitioner (A.R.N.P.).

This benefit does not cover immunizations and Outpatient well-baby exams. See the Preventive Care benefit for coverage of immunizations and Outpatient well-baby exams.

Nutritional Evaluation
Charges made for nutritional evaluation and counseling when diet is part of the medical management of a documented organic disease.

Obesity Treatment
Covered Expenses include Charges made by a Physician, licensed or certified dietician, nutritionist or Hospital for the non-surgical treatment of obesity for the following Outpatient weight management services:

- An initial medical history and physical exam; or
- Diagnostic tests given or ordered during the first exam

The Plan covers Inpatient or Outpatient Charges made by a Hospital or a Physician for the Medically Necessary surgical treatment of Morbid Obesity. Bariatric surgery must be approved in advance by claims Administrator.

Covered Expenses include one Morbid Obesity surgical procedure within a two-year period, beginning with the date of the first Morbid Obesity surgical procedure, unless a multi-stage procedure is planned.

The Plan does not cover

- medical and surgical services to alter appearances or physical changes that are the result of any medical or surgical services performed for the treatment or control of Obesity or clinically severe (Morbid) Obesity; and
- bariatric surgery when done for cosmetic reasons; and
- weight loss programs or treatments, whether or not they are prescribed or recommended by a Physician or under medical supervision.

Organ Transplant Services
The Transplants benefit is not subject to a separate benefit maximum other than the maximums for transport and lodging and for donor costs described below. This benefit covers medical services only if provided by Providers or "Approved Transplant Centers." Please see the transplant benefit requirements later in this benefit for more information about Approved Transplant Centers.

Organ transplants and bone marrow/stem cell reinfusion procedures must not be considered Experimental or Investigational for the treatment of Your condition. (Please see the "Definitions" section in this Certificate for the definition of "Experimental/Investigational" services.) We reserve the right to base coverage on all of the following:

Organ transplants and bone marrow/stem cell reinfusion procedures must meet Our criteria for coverage. We review the medical indications for the transplant, documented effectiveness of the procedure to treat the condition, and failure of medical alternatives.

The types of organ transplants and bone marrow/stem cell reinfusion procedures that currently meet Our criteria for coverage are:

- Heart
- Heart/double lung
- Single lung
- Double lung
- Liver
- Kidney
- Pancreas

- Pancreas with kidney
- Bone marrow (autologous and allogeneic)
- Stem cell (autologous and allogeneic)

For the purposes of this Plan, the term "transplant" does not include cornea transplantation, skin grafts or the transplant of blood or blood derivatives (except for bone marrow or stem cells). These procedures are covered on the same basis as any other covered surgical procedure.

- Your medical condition must meet Our written standards.
- The transplant or reinfusion must be furnished in an Approved Transplant Center, (an "Approved Transplant Center" is a Hospital or other Provider that has developed expertise in performing organ transplants, or bone marrow or stem cell reinfusion, and is approved by Us.) Whenever medically possible, We will direct You to an Approved Transplant Center that We have contracted with for transplant services.

If none of Our centers or the Approved Transplant Centers can provide the type of transplant You need, this benefit will cover a transplant center that meets written approval standards set by Us.

The following services are included in the Transplant Services benefits:

- **Inpatient Facility Services** – Benefits for services in a facility or an approved transplant center are subject to Your Policy Year Deductible and Coinsurance.

- **Inpatient Professional and Surgical Services** – Benefits for a Provider or an approved transplant Provider are subject to Your Policy Year Deductible and Coinsurance.

- **Outpatient Surgical Facility Services** – Benefits for a facility or an Approved Transplant Center are subject to Your Policy Year Deductible and Coinsurance.

- **Outpatient Professional Visits** – You pay the Copay as stated in the Schedule of Benefits per visit in an office setting to a Provider or an approved transplant Provider. Please see the Schedule of Benefits section of this Certificate for details about the professional office visit Copay.

  When a professional visit is not provided in an office setting, benefits are subject to Your Participating Provider Policy Year Deductible and Coinsurance.

- **Other Outpatient Professional Services** – Benefits for a Provider or an approved transplant Provider are subject to Your Deductible and Coinsurance.

- **Transport and Lodging** – The transport and lodging benefits are subject to Your Deductible, but are not subject to Your Coinsurance.

  Reasonable and necessary expenses for transportation and lodging for the transplant recipient (while not confined) and one companion, except as stated below, are covered but limited as follows:
  - The transplant recipient must reside more than 50 miles from the Approved Transplant Center unless Medically Necessary treatment protocols require the member to remain closer to the transplant center.
  - The transportation must be to and/or from the site of the transplant for the purposes of an evaluation, the transplant procedure, or necessary post-discharge follow-up.
  - When the recipient is a dependent minor child, benefits for transportation, lodging and meal expenses for the recipient and 2 companions will be provided.
  - When the recipient is not a dependent minor child, benefits for transportation, lodging and meal expenses for the recipient and one companion will be provided.
  - Covered transportation and lodging expenses incurred by the transplant recipient and companions are limited to a one room, double occupancy. Tobacco, alcohol, drug and meal expenses are excluded from coverage.

- **Recipient Costs** – This benefit covers transplant and reinfusion-related expenses, including the preparation regiment for a bone marrow or stem cell reinfusion. Also covered are anti-rejection drugs administered by the transplant center during the Inpatient or Outpatient stay in which the transplant was performed.

- **Donor Costs –** Coverage for organ procurement costs are limited to costs directly related to the procurement of an organ from a cadaver or a live donor. Covered donor services include selection, removal (harvesting) and evaluation of the donor organ, bone marrow or stem cell; transportation of donor organ, bone marrow and stem cells, including the surgical and harvesting teams; donor acquisition costs such as testing and typing expenses; and storage costs for bone marrow and stem cells for a period of up to 12 months.

This benefit does not cover:

- Services and supplies that are payable by any government, foundation or charitable grant. This includes services performed on potential or actual living donors and recipients, and on cadavers.
- Donor costs for an organ transplant or bone marrow or stem cell reinfusion that is not covered under this benefit, or for a recipient who is not a Covered Person.
- Donor costs for which benefits are available under other group or individual coverage.
- Non-human or mechanical organs, unless We determine they are not Experimental/Investigational services (please see the "Definitions" section in this Certificate).
- Personal care items.
- Under the Transportation and Lodging benefit, expenses for travel within 50 miles from Your home, laundry bills, mobile phone Charges, Charges for alcohol or tobacco products, or transportation Charges that exceed coach class rates.
- Planned storage of blood for more than 12 months against the possibility it might be used at some point in the future.

Orthognathic Surgery

Orthognathic surgery to repair or correct a severe facial deformity or disfigurement that orthodontics alone cannot correct provided:

- The deformity or disfigurement is accompanied by a documented clinically significant functional impairment, and there is a reasonable expectation that the procedure will result in meaningful functional improvement; or
- The orthognathic surgery is Medically Necessary as a result of tumor, trauma, disease; or
- The orthognathic surgery is performed prior to age 19 and is required as a result of severe congenital facial deformity or congenital condition.

Repeat or subsequent orthognathic surgeries for the same condition are covered only when the previous orthognathic surgery met the above requirements, and there is a high probability of significant additional improvement as determined by the utilization review Physician.

Private Duty Nursing

Private duty nursing services must be preauthorized.

Covered Expenses include private duty nursing provided by an R.N. or L.P.N. if the Covered Person's condition requires skilled nursing care and visiting nursing care is not adequate. However, Covered Expenses will not include private duty nursing for any shifts during a Policy Year in excess of the Private Duty Nursing care visit limit. Each period of private duty nursing of up to eight hours will be deemed to be one private duty nursing shift.

The Plan also covers skilled observation for up to one four-hour period per day, for up to 10 consecutive days following:

- A change in Your medication;
- Treatment of an urgent or Emergency Medical Condition by a Physician;
- The onset of symptoms indicating a need for emergency treatment;
- Surgery;
- An Inpatient Hospital stay.

Private Duty Nursing Limits

Unless specified above, not covered under this benefit are Charges for:

- Nursing care that does not require the education, training and technical skills of an R.N. or L.P.N.
- Nursing care assistance for daily life activities, such as:
  - Transportation;
  - Meal preparation;
  - Vital sign charting;
  - Companionship activities;
  - Bathing;
  - Feeding;
  - Personal grooming;
  - Dressing;
  - Toileting; and
  - Getting in/out of bed or a chair.
- Nursing care provided for skilled observation.
- Nursing care provided while You are an Inpatient in a Hospital or Health Care Facility, provided the care can adequately be provided by the facility's general nursing staff, if it were fully staffed.
- A service provided solely to administer oral medicine, except where law requires an R.N. or L.P.N. to administer medicines.

Psycho-Educational Testing
Psycho-educational testing conducted by a licensed clinical, educational, or counseling Psychologist in order to assess and diagnose functional limitations due to learning disabilities, including, but not limited to, attention deficit hyperactivity disorder (ADHD). This benefit covers psycho-educational test batteries including aptitude, achievement, and cognitive tests to assess for cognitive and learning disabilities; a written report listing test scores, testing procedures followed, interpretation of test results, and date(s) of testing. Consultation with the student to review test results and recommendations for appropriate academic accommodation are also covered under this benefit.

Reconstructive Surgery
Charges made for reconstructive surgery or therapy to repair or correct a severe physical deformity or disfigurement which is accompanied by functional deficit; (other than abnormalities of the jaw or conditions related to TMJ disorder) provided that: the surgery or therapy restores or improves function; reconstruction is required as a result of Medically Necessary, non-cosmetic surgery; or the surgery or therapy is performed prior to age 19 and is required as a result of the congenital absence or agenesis (lack of formation or development) of a body part. Repeat or subsequent surgeries for the same condition are covered only when there is the probability of significant additional improvement as determined by the utilization review Physician.

Short-Term Rehabilitative Therapy
Short-term Rehabilitative Therapy that is part of a rehabilitation program, including physical, speech, occupational, cognitive, osteopathic manipulative, cardiac rehabilitation and pulmonary rehabilitation therapy, when provided in the most medically appropriate setting.

The following limitation applies to Short-term Rehabilitative Therapy:
- Occupational therapy is provided only for purposes of enabling persons to perform the activities of daily living after an Injury or Sickness.

Short-term Rehabilitative Therapy services that are not covered include but are not limited to:
- Sensory integration therapy, group therapy; treatment of dyslexia; behavior modification or myofunctional therapy for dysfluency, such as stuttering or other involuntarily acted conditions without evidence of an underlying medical condition or neurological disorder;
- Treatment for functional articulation disorder such as correction of tongue thrust, lisp, verbal apraxia or swallowing dysfunction that is not based on an underlying diagnosed medical condition or Injury; and
- Maintenance or Preventive Treatment consisting of routine, long term or non-Medically Necessary care provided to prevent recurrence or to maintain the patient's current status.

Multiple Outpatient services provided on the same day constitute one day.

Services that are provided by a chiropractic Physician are not covered. These services include the conservative management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to restore motion, reduce pain and improve function.

Telehealth
This Plan provides benefits for covered services that are appropriately provided through Telehealth, subject to the terms and conditions of the Plan. In-person contact between a health care Provider and the patient is not required for these services, and the type of setting where these services are provided is not limited. "Telehealth" is the means of providing health care services using information and communication technologies in the consultation, diagnosis, treatment, education, and management of the patient's health care when the patient is located at a distance from the health care Provider. Telehealth does not include consultations between the patient and the health care Provider, or between health care Providers, by telephone, facsimile machine, or electronic mail.

Equipment costs and transmission costs associated with Telehealth are not reimbursable.

Temporomandibular Joint (TMJ) Disorders
Benefits for medical and dental services and supplies for the treatment of temporomandibular joint (TMJ) disorders are provided on the same basis as any other medical or dental condition. Treatment of TMJ disorders is not covered under other benefits of this Plan.

This benefit includes coverage for Inpatient and Outpatient facility and professional care, including professional visits.

Medical and dental services and supplies are those that meet all of the following requirements:
- Reasonable and appropriate for the treatment of a disorder of the temporomandibular joint, under all the factual circumstances of the case.
- Effective for the control or elimination of one or more of the following, caused by a disorder of the temporomandibular joint: pain, infection, disease, difficulty in speaking, or difficulty in chewing or swallowing food.
- Recognized as effective, according to the professional standards of good medical or dental practice.
- Not Experimental or Investigational, as determined by Us according to the criteria stated under "Definitions," or primarily for cosmetic purposes.

Transgender Services

Services and supplies provided in connection with gender transition when You have been diagnosed with gender identity disorder or gender dysphoria by a Physician. This coverage is provided according to the terms and conditions of this Certificate that apply to all other covered medical conditions, including medical necessity requirements, utilization management, and exclusions for cosmetic services. Coverage includes, but is not limited to, Medically Necessary services related to gender transition such as transgender surgery, hormone therapy, psychotherapy, and vocal training.

Coverage is provided for specific services according to the Certificate's benefits that apply to that type of service generally, if the Certificate includes coverage for the service in question. If a specific coverage is not included, the service will not be covered. For example, transgender surgery would be covered on the same basis as any other covered, Medically Necessary surgery; hormone therapy would be covered under the Certificates Prescription Drug benefits.

Services that are excluded on the basis that they are cosmetic include, but are not limited to, liposuction, facial bone reconstruction, voice modification surgery, breast implants, and hair removal. Transgender services are subject to prior authorization in order for coverage to be provided.

VI. Prescription Drug Benefits

Covered Expenses

If You or any one of Your Dependents, while insured for Prescription Drug Benefits, incurs expenses for Charges made by a Pharmacy, for Medically Necessary Prescription Drugs or Related Supplies ordered by a practitioner licensed to prescribe, We will provide coverage for those expenses as shown in the Schedule of Benefits. Coverage also includes Medically Necessary Prescription Drugs and Related Supplies dispensed for a prescription issued to You or Your Dependents by a licensed Dentist for the prevention of infection or pain in conjunction with a dental procedure.

Administered by a Medical Provider

This Plan also covers Prescription Drugs when they are administered to You as part of a Physician's visit, home care visit, or at an Outpatient facility. This includes Drugs for Infusion Therapy, chemotherapy, Specialty Drugs, blood products, and office-based injectables that must be administered by a Provider. This section applies when Your Participating Provider orders the Drug and administers it to You and is paid as a Medical Expense

Benefits for Drugs that You inject or get at a Pharmacy (i.e., Self-Administered Injectable Drugs) are covered under the Prescription Drug Benefits.

Conditions of Service

To be a covered service, the Prescription Drug or medicine must be:

- Prescribed in writing by a practitioner licensed to prescribe and dispensed within one Policy Year of being prescribed, subject to federal, state laws or local jurisdictional rules;
- To be a Covered Expense, the Prescription Drug or medicine must be prescribed for use within the approved package label for the drug and/or a recognized treatment for an indication in standard reference compendia or in the clinical literature. Any coverage for use outside of the approved package label shall also include Medically Necessary services associated with the administration of the drug;
- If purchased outside of the United States, the purchase and distribution is subject to the local laws and local jurisdictional responsibilities;
- For the direct care and treatment of the Covered Person's Sickness, Injury or condition. Dietary supplements, health aids or drugs for cosmetic purposes are not included;
- Purchased from a licensed retail or mail order Pharmacy;
- Not prohibited by law.

Benefits are available for the following:

- Prescription Drugs from either a retail Pharmacy or Our mail order Pharmacy;
- Specialty Drugs;
- Self-Administered Injectable Drugs. These are Drugs that do not need administration or monitoring by a Provider in an office or Facility. Office-based injectable and infused Drugs that need Provider administration and/or supervision are covered under the medical portion of this Plan by Medical Provider benefit;
- Self-injectable insulin and supplies and equipment used to administer insulin including syringes;
- Disposable needles and syringes needed for injecting Covered Prescription Drugs and supplements;
- All FDA-approved contraceptive methods for women, including over-the-counter items, if prescribed by a practitioner licensed to prescribe (male contraceptive methods are not covered). This Plan covers at least one form of contraception in each of the methods identified by the FDA in its current Birth Control Guide including but not limited to oral, injectable, and implantable contraceptives, diaphragms, contraceptive patches and rings, and emergency contraceptives. In order to be covered as preventive care, contraceptive Prescription Drugs must be either a Generic or single-source Brand Drug (a single-source Brand Drug is a Drug for which there is no Generic equivalent), be prescribed by a practitioner licensed to prescribe, and obtained from a Participating Pharmacy. Multi-source Brand Drugs (those that have a Generic equivalent) will be covered as preventive care if Medically Necessary as determined by Your practitioner licensed to prescribe (see 'Prior Authorization' later in this part). Certain contraceptives are covered under the Plan's medical benefits. Please see that section in the part Covered Expenses Benefit Descriptions under the section "Preventive Care" for more details;
- Vaccinations including administration (ex. Influenza vaccines and others) that are able to be administered by pharmacists under applicable regulation;
- Appropriate pain management medications for terminally ill patients.

Your Payments

Coverage for Prescription Drugs and Related Supplies purchased at a Pharmacy may be subject to a Deductible, Copayment or Coinsurance. Please refer to the Schedule of Benefits for any required cost sharing or maximums if applicable.

Limitations

Each Prescription Order or refill shall be limited as follows:

- up to a consecutive 180-day supply at a retail Pharmacy unless limited by the drug manufacturer's packaging; or
- up to a consecutive 180-day supply at a mail order Pharmacy, unless limited by the drug manufacturer's packaging; or
- to a dosage and/or dispensing limit as determined by the Pharmacy &Therapeutics (P&T) Committee.

Definitions

To understand the Your Prescription Drug Benefits, it may be helpful to review these important terms:

Compound Drugs or Compound Medicines means a compounded prescription that is the result of mixing two or more drug ingredients into a final dosage form (tablet, capsule, liquid, suspension, cream, ointment, gel, etc.). The act of compounding is a practice in which a licensed pharmacist, a practitioner licensed to prescribe, or, in the case of an outsourcing facility, a person under the supervision of a licensed pharmacist, combines, mixes, or alters ingredients of a drug to create a medication tailored to the needs of an individual patient.

Drugs (Prescription Drugs) means; a drug which has been approved by the Food and Drug Administration (FDA) for safety and efficacy; certain drugs approved under the FDA's Drug Efficacy Study Implementation review; or drugs marketed prior to 1938 and not subject to review, and which can, under federal or state law, be dispensed only pursuant to a Prescription Order.

For purposes of this benefit, insulin is considered a Prescription Drug.

Fixed Dose Combination Drugs means manufactured fixed dose combination medicines that because of unique formulation characteristics permits market exclusivity for these medicines and single source brand drug status.

Generic Prescription Drug (Generic) is a pharmaceutical equivalent of one or more Brand Name Drugs and must be approved by the Food and Drug Administration as meeting the same standards of safety, purity, strength and effectiveness as the Brand Name Drug. Generally Generic Prescription Drugs are covered under as a Tier 1 drug.

Injectable Drug is a drug that can put into the body with a needle or syringe. The medicine is put under the skin, or into a vein.

Non-Participating Pharmacy is a Pharmacy that does not have a Participating Pharmacy agreement in effect with Us at the time services are rendered. The Covered Person will be responsible for a larger portion of the pharmaceutical bill when the Covered Person goes to a Non-Participating Pharmacy.

A **Non-preferred Brand Name Prescription Drug** is one not included on the Plan's formulary or list of preferred prescriptions. Non-preferred Brand Name Prescription Drugs have a higher coinsurance than Preferred Brand Name Prescription Drugs. You pay more if You use non-preferred drugs than if You opt for Generics and Brand Name Prescription Drugs. These drugs are generally covered as a Tier 3 drug.

Participating Pharmacy is a retail Pharmacy with which We or Our designee have contracted to provide prescription services to Covered Persons, or a designated home delivery Pharmacy with which We or Our designee have contracted to provide home delivery prescription services to Covered Persons. A home delivery Pharmacy is a Pharmacy that provides Prescription Drugs through mail order.

Pharmacy means a licensed retail Pharmacy, or a home delivery (mail order) Pharmacy.

Preferred Brand Name Prescription Drug (Brand Name) is a Prescription Drug that has been patented and is only produced by one manufacturer. These drugs are generally covered either as a Tier 2 drug.

Prescription means a written order by a practitioner licensed to prescribe.

Specialty Drugs are "bioengineered" oral or injectable medicines that target and treat complex medical conditions including: blood disorders, cancers, infertility, hormone or enzyme deficiencies, multiple sclerosis, rheumatoid arthritis, and a growing list of obscure or "orphan" diagnoses. Specialty drugs are complex compounds and some have unique "handling" requirements. The FDA in selected situations has required dispensing from a single Pharmacy or a limited set of "approved" pharmacies. Some "specialty" drugs are oral tablets or capsules while others require injection.

Important Details about Prescription Drug Coverage

The Prescription Drug coverage under this benefit Plan includes certain features to determine when Prescription Drugs should be covered, which are described below. As part of these features, the prescribing practitioner may be asked to provide more information before a decision regarding Medical Necessity can be determined. Quantity and or age limits may be set for specific Prescription Drugs or use recommendations made as part of the Medical Policy and Technology Assessment Committee and/or Pharmacy and Therapeutics Process.

Prescription Drug benefits may depend on reviews to decide when Drugs should be covered. These reviews may include Prior Authorization, Step Therapy, use of a Prescription Drug List or formulary, Therapeutic Substitution, day / supply limits, and other utilization reviews. Your Participating Pharmacist will be told of any rules when You fill a Prescription, and will also be told about any details We would need to decide benefits.

Drug Utilization Review

Prescription Drug benefits include utilization review of Prescription Drug usage for Your health and safety. Certain Drugs may require prior authorization. Also, a Participating Pharmacist can help arrange prior authorization or dispense an Emergency amount. If there are patterns of over utilization or misuse of Drugs, We will notify Your personal practitioner licensed to prescribe and Your pharmacist. We reserve the right to limit benefits to prevent over utilization of Drugs.

Step Therapy
Step therapy is a process in which You may need to use one type of drug before We will cover another. We or Our Administrator will check certain Prescription Drugs to make sure that proper prescribing guidelines are followed. These guidelines help You get high quality and cost effective Prescription Drugs. If a practitioner licensed to prescribe decides that a certain Prescription Drug is needed, the prior authorization will apply.

Day Supply and Refill Limits
Certain day supply limits apply to Prescription Drugs as listed in the Schedule of Benefits. In most cases, You must use a certain amount of Your Prescription (e.g., 85%) before it can be refilled.

Prior Authorization for Specialty Drugs, Compound Drugs and/or Fixed Dose Combination Drugs
Prior authorization may be needed for certain Prescription Drugs to make sure proper use and guidelines for Prescription Drug coverage are followed. We or the Administrator will contact Your Provider to get the details they need to decide if prior authorization should be given. We or the Administrator will give the results of our decision to both You and Your Provider. The prior authorization process is also used to approve requests from Your Provider for contraceptive methods that are Medically Necessary for You based on Your medical or personal history.

Prior authorization procedures and requirements for coverage are based on clinical need and therapeutic rationale. Administration of the prior authorization process considers the desired outcome for the patient, the design of the drug benefit, the value to Us, and all statutory and regulatory requirements. The process offers the prescriber an opportunity to justify the therapeutic basis for the prescribed medication and receive information concerning the acceptance and payment of claims for a particular drug.

You may need to try a Drug other than the one originally prescribed if We determine that it should be clinically effective for You. However, if We determine through the prior authorization process that the Drug originally prescribed is Medically Necessary, You will be provided the Drug originally requested at the applicable Copayment. If approved, Drugs requiring prior authorization will be provided to You after You make the required Copayment. (If, when You first become enrolled, You are already being treated for a medical condition with a Drug that has been appropriately prescribed and is considered safe and effective for Your medical condition and You underwent a prior authorization process under a prior Plan which required You to take different Drugs, We will not require You to try a Drug other than the one You are currently taking.)

The prior authorization review process is outlined below:
1. A rejected Prescription Drug claim will initiate a request for prior authorization with a request for patient demographic and necessary clinical data of the practitioner licensed to prescribe.
2. Our Pharmacy Benefit Manager (PBM) reviews available data and determines:
    a. Information provided is sufficient to make a determination;
    b. Information provided is insufficient to make a determination and initiates fax request for necessary clinical data to prescribing practitioner within 24 hours following receipt of review request.
3. Review of historic medication claim data, standard clinical references and clinical data/information received from the practitioner licensed to prescribe.
4. Match of available data and information with labeled indication(s) for prescribed medication requiring authorization and against generally accepted clinical authorization criteria.
5. A recommendation to accept claims for payment will be made in writing and provided to Us and removal of Prior Authorization criteria in the Rx claim system will be completed.
6. A recommendation to not accept claims for payment will be made in writing and will be provided to Us, the practitioner licensed to prescribe, the Prescription Drug claims processor and the Covered Person.
7. Review and recommendation to be completed within 48 hours following receipt of clinical data from practitioner.

If prior authorization is denied You have the right to file a grievance as outlined in the part WHEN YOU HAVE A COMPLAINT OR APPEAL.

For a list of Drugs that need prior authorization, please call the telephone number listed on Your ID Card or visit www.geo-blue.com. The list will be reviewed and updated from time to time. Including a Drug or related item on the list does not promise coverage under Your Prescription Drug coverage. Your Provider may check with us to verify Drug coverage, to find out whether any quantity (amount) and/or age limits apply, and to find out which drugs are covered under the Prescription Drug coverage.

Exclusions

No payment will be made for the following expenses:

1. drugs available over the counter that do not require a Prescription by federal or state law or applicable law in the jurisdiction where the drug is purchased;
2. any drug that is a pharmaceutical alternative to an over-the-counter drug other than insulin;
3. a drug class in which at least one of the drugs is available over the counter and the drugs in the class are deemed to be therapeutically equivalent as determined by the P&T Committee;
4. Contrary to approved medical and professional standards: Drugs given to You or prescribed in a way that is against approved medical and professional standards of practice;
5. Compound drugs. Case by case review is available for unique patient clinical circumstances where the only solution is to provide a compounded medicine. See the Drug Utilization Review section of this benefit;
6. Fixed Dose Combination Drugs that are not supported by medical and/or pharmaceutical literature describing a therapeutic advantage in clinical outcomes to the same or similar separately administered medicines in comparable daily doses. Case by case review is available for unique patient clinical circumstances where the only solution is to provide a Fixed Dose Combination drug. See the Drug Utilization Review section of this benefit
7. any injectable drugs that require Physician supervision and are not typically considered self-administered drugs. The following are examples of Physician supervised drugs: Injectables used to treat hemophilia and RSV (respiratory syncytial virus), chemotherapy injectables and endocrine and metabolic agents.
8. Food and Drug Administration (FDA) approved drugs used for purposes other than those approved by the FDA unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia (The United States Pharmacopoeia Drug Information, The American Medical Association Drug Evaluations; or The American Hospital Formulary Service Drug Information) or in medical literature. Medical literature means scientific studies published in a peer-reviewed national professional medical journal and meets accepted clinical criteria for use;
9. prescription vitamins (other than prenatal vitamins), dietary supplements unless state or federal law requires coverage of such drugs;
10. prescription and nonprescription supplies (such as ostomy supplies), devices, and appliances other than Related Supplies;
11. implantable contraceptive products;
12. weight management drugs;
13. diet pills or appetite suppressants (anorectics);
14. anabolic steroids;
15. growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition);
16. prescription smoking cessation products;
17. biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications;
18. drugs used for cosmetic purposes such as drugs used to reduce wrinkles, drugs to promote hair growth as well as drugs used to control perspiration and fade cream products;
19. drugs or supplies used for the treatment of erectile dysfunction, impotence or sexual dysfunction or inadequacy in oral, injectable and topical forms or any other form used internally or externally;
20. replacement of Prescription Drugs and Related Supplies due to loss or theft;
21. drugs used to enhance athletic performance;
22. drugs which are to be taken by or administered to You while You are a patient in a licensed Hospital, Skilled Nursing Facility, rest home or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals;
23. Prescriptions more than one year from the original date of issue;
24. any drugs that are Experimental or Investigational as described under the Medical “Exclusions” section of Your Certificate.

Other limitations are shown in the Medical “Exclusions” section of Your Certificate.

Reimbursement/Filing a Claim

When You or Your Dependents purchase Your Prescription Drugs or Related Supplies through a retail Participating Pharmacy, You pay any applicable Copayment, or Coinsurance and/or Deductible shown in the Schedule of Benefits at the time of purchase. You do not need to file a claim form.

If You or Your Dependents purchase Your Prescription Drugs or Related Supplies through a Non-Participating Pharmacy, You pay the full cost at the time of purchase. You must submit a claim form to be reimbursed.

To purchase Prescription Drugs or Related Supplies from a home delivery (mail order) Participating Pharmacy, contact customer service for assistance.

VII. Exclusions, Expenses Not Covered and General Limitations

Exclusions and Expenses Not Covered

Additional coverage limitations determined by Plan or Provider type are shown in the Schedule of Benefits. Payment for the following is specifically excluded from this Plan:

1. Care for health conditions that are required by state or local law to be treated in a public facility.
2. Care required by state or federal law to be supplied by a public school system or school district.
3. Care for military service disabilities treatable through governmental services if You are legally entitled to such treatment and facilities are reasonably available.
4. For or in connection with an Injury or Sickness which is due to participation in riot, civil commotion or police action.
5. For claim payments that are illegal under applicable law.
6. Charges which You are not obligated to pay or for which You are not billed or for which You would not have been billed except that they were covered under this Plan.
7. Assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Care or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
8. Non-Treatment Facilities, Institutions or Programs - Benefits are not provided for institutional care, housing, incarceration or programs from facilities that are not licensed to provide medical or behavioral health treatment for covered conditions. Examples are prisons, nursing homes, juvenile detention facilities, group homes, foster homes and adult family homes. Benefits are provided for Medically Necessary medical or behavioral health treatment received in these locations
9. For or in connection with Experimental, Investigational or unproven services.

   Experimental, Investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the utilization review Physician to be:

   - Not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or Sickness for which its use is proposed;
   - not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use;
   - the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" section(s) of this Plan; or
   - the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the "Clinical Trials" section(s) of this Plan.
10. Cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance.
11. The following services are excluded from coverage regardless of clinical indications: macromastia or gynecomastia surgeries; abdominoplasty; panniculectomy; rhinoplasty; blepharoplasty for cosmetic reasons; redundant skin surgery; removal of skin tags for cosmetic reasons; acupressure; craniosacral/cranial therapy; dance therapy, movement therapy; applied kinesiology; rolfing; prolotherapy; and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
12. Medical and surgical services, initial and repeat, intended for the treatment or control of Obesity, except for treatment of clinically severe (Morbid) Obesity as shown in Covered Expenses, including: medical and surgical services to alter appearance or physical changes that are the result of any surgery performed for the management of Obesity or clinically severe (Morbid) Obesity; and weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.
13. Unless otherwise covered in this Plan, for reports, evaluations, physical examinations, or Hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.
14. Court-ordered treatment or Hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this Plan.
15. Reversal of male or female voluntary sterilization procedures.
16. Any services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmia, and premature ejaculation.
17. Medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this Plan.
18. Non-medical counseling or ancillary services, including but not limited to Custodial Care services, education, training, vocational rehabilitation, behavioral training, gym or swim therapy, legal or financial counseling, biofeedback, neuro-feedback, hypnosis, sleep therapy, employment counseling, back to school, return to work services, work hardening programs, driving safety, and services, training, educational therapy or other non-medical ancillary services for learning disabilities, developmental delays or intellectual disabilities.
19. Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
20. Family and marital counseling except when Medically Necessary to treat the diagnosed mental or substance use disorder or disorders of a Covered Person.

21. Consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Home Health Services" or "Breast Reconstruction and Breast Prostheses" sections of this Plan.
22. Personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.
23. Artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets and wigs other than for scalp hair prostheses worn due to alopecia areata or due to cancer treatment.
24. Hearing aids, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs), except as covered under this Plan as shown in the Schedule of Benefits section. A hearing aid is any device that amplifies sound.
25. Aids or devices that assist with nonverbal communications, including but not limited to communication boards, pre-recorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books except as shown in the Covered Expenses section for treatment of autism.
26. Vision treatment, eye exercise, equipment or surgery to correct eyesight, such as laser treatment, refractive keratotomy (RK) and photorefractive Keratotomy (PRK). We will pay for eligible treatment or surgery of a detached retina, glaucoma, cataracts or keratoconus.
27. Vision exams, lenses and hardware, including eyeglasses, contact lenses and the examination for prescribing or fitting of glasses or contact lenses or for determining the refractive state of the eye. This Plan never covers non-prescription eyeglasses or contact lenses, or other special purpose vision aids (such as magnifying attachments), sunglasses or light-sensitive lenses, even if prescribed.
28. All non-injectable Prescription Drugs, injectable Prescription Drugs that do not require Physician supervision and are typically considered self-administered drugs, Non-Prescription Drugs, and Investigational and Experimental drugs, except as provided in this Plan.
29. Routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
30. Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs or voluntary support groups.
31. Genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
32. Dental implants for any condition.
33. Dental services or supplies except as specifically stated.
34. Orthodontia services, regardless of condition, including casts, models, X-rays, photographs, examinations, appliances, braces and retainers.
35. Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
36. Blood administration for the purpose of general improvement in physical condition.
37. Cosmetics, dietary supplements and health and beauty aids.
38. Drugs, supplies, equipment or procedures to replace hair, slow hair loss or stimulate hair growth.
39. All nutritional supplements and formulae except for infant formula needed for the treatment of inborn errors of metabolism.
40. For or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit. This exclusion does not apply if the Group does not furnish Worker's Compensation or Defense Based Act insurance.
41. Telephone, e-mail, and Internet consultations unless specifically approved by the Administrator due to limited resources while located in a country outside of the United States.

General Limitations

No payment will be made for expenses incurred for You or any one of Your Dependents:

1. For Charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such Charges are directly related to a military-service-connected Injury or Sickness.
2. To the extent that You or any one of Your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid.
3. To the extent that payment is unlawful where the person resides when the expenses are incurred.
4. For Charges which would not have been made if the person had no insurance.
5. To the extent that they are more than Maximum Reimbursable Charges.
6. To the extent of the exclusions imposed by any certification requirement shown in this Plan.
7. Expenses for supplies, care, treatment, or surgery that are not Medically Necessary.
8. Charges made by any covered Provider who is a member of Your family or Your Dependent's family.
9. To the extent that such payments would be prohibited by law.

VIII. General Provisions

Coordination of Benefits

This section applies if You or any one of Your Dependents is covered under more than one plan and determines how benefits payable from all such plans will be coordinated. You should file all claims with each plan. For claims incurred within the United States, You should file all claims under each plan. For claims incurred outside the United States, if You file claims with more than one plan, You must indicate, at the time of filing a claim under this Plan that You also have or will be filing Your claim under another plan.

Definitions
For the purposes of this section, the following terms have the meanings set forth below:

Plan
Any of the following that provides benefits or services for medical, dental or vision care or treatment:

- Group insurance and/or group-type coverage, whether insured or self-insured which neither can be purchased by the general public, nor is individually underwritten, including closed panel coverage.
- Coverage under Medicare and other governmental benefits as permitted by law, except Medicaid and Medicare supplement policies.
- Medical benefits coverage of group, group-type, and individual automobile contracts.

Each Plan or part of a Plan which has the right to coordinate benefits will be considered a separate Plan.

Closed Panel Plan
A Plan that provides medical or dental benefits primarily in the form of services through a panel of employed or contracted Providers, and that limits or excludes benefits provided by Providers outside of the panel, except in the case of emergency or if referred by a Provider within the panel.

Primary Plan
The Plan that determines and provides or pays benefits without taking into consideration the existence of any other Plan.

Secondary Plan
A Plan that determines, and may reduce its benefits after taking into consideration, the benefits provided or paid by the Primary Plan. A Secondary Plan may also recover from the Primary Plan the Reasonable Cash Value of any services it provided to You.

Allowable Expense
A necessary, reasonable and customary service or expense, including Deductibles, coinsurance or Copayments that is covered in full or in part by any Plan covering You. When a Plan provides benefits in the form of services, the Reasonable Cash Value of each service is the Allowable Expense and is a paid benefit.

Examples of expenses or services that are not Allowable Expenses include, but are not limited to the following:

- An expense or service or a portion of an expense or service that is not covered by any of the Plans is not an Allowable Expense.
- If You are confined to a private Hospital room and no Plan provides coverage for more than a semiprivate room, the difference in cost between a private and semiprivate room is not an Allowable Expense.
- If You are covered by two or more Plans that provide services or supplies on the basis of reasonable and customary fees, any amount in excess of the highest reasonable and customary fee is not an Allowable Expense.
- If You are covered by one Plan that provides services or supplies on the basis of reasonable and customary fees and one Plan that provides services and supplies on the basis of negotiated fees, the Primary Plan's fee arrangement shall be the Allowable Expense.
- If Your benefits are reduced under the Primary Plan (through the imposition of a higher Copayment amount, higher coinsurance percentage, a Deductible and/or a penalty) because You did not comply with Plan provisions or because You did not use a preferred Provider, the amount of the reduction is not an Allowable Expense. Such Plan provisions include second surgical opinions and precertification of admissions or services.

Claim Determination Period
A calendar year, but does not include any part of a year during which You are not covered under this Certificate or any date before this section or any similar provision takes effect.

Reasonable Cash Value
An amount which a duly licensed Provider of health care services usually Charges patients and which is within the range of fees usually charged for the same service by other health care Providers located within the immediate geographic area where the health care service is rendered under similar or comparable circumstances.

Order of Benefit Determination Rules
A Plan that does not have a coordination of benefits rule consistent with this section shall always be the Primary Plan. If the Plan does have a coordination of benefits rule consistent with this section, the first of the following rules that applies to the situation is the one to use:

- The Plan that covers You as an enrollee or an employee shall be the Primary Plan and the Plan that covers You as a Dependent shall be the Secondary Plan;
- If You are a Dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the Plan which covers the parent whose birthday falls first in the calendar year as an enrollee or employee;
- If You are the Dependent of divorced or separated parents, benefits for the Dependent shall be determined in the following order:
  - first, if a court decree states that one parent is responsible for the child's healthcare expenses or health coverage and the Plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;
  - then, the Plan of the parent with custody of the child;
  - then, the Plan of the spouse of the parent with custody of the child;
  - then, the Plan of the parent not having custody of the child, and
  - finally, the Plan of the spouse of the parent not having custody of the child.
- The Plan that covers You as an active employee (or as that employee's Dependent) shall be the Primary Plan and the Plan that covers You as laid-off or retired employee (or as that employee's Dependent) shall be the secondary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- The Plan that covers You under a right of continuation which is provided by federal or state law shall be the Secondary Plan and the Plan that covers You as an active employee or retiree (or as that employee's Dependent) shall be the Primary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- If one of the Plans that covers You is issued out of the state whose laws govern this Certificate, and determines the order of benefits based upon the gender of a parent, and as a result, the Plans do not agree on the order of benefit determination,
- The Plan with the gender rules shall determine the order of benefits.

If none of the above rules determines the order of benefits, the Plan that has covered You for the longer period of time shall be primary.

When coordinating benefits with Medicare, this Plan will be the Secondary Plan and determine benefits after Medicare, where permitted by the Social Security Act of 1965, as amended. However, when more than one Plan is secondary to Medicare, the benefit determination rules identified above, will be used to determine how benefits will be coordinated.

Effect on the Benefits of This Plan
If this Plan is the Secondary Plan, this Plan may reduce benefits so that the total benefits paid by all Plans for a Claim are not more than 100% of the total of all Allowable Expenses.

When the Allowable Expenses incurred for a Covered Person in any Claim are less than the sum of:
a. the benefits that would be payable under This Plan without applying the Coordination of Benefits provision; and
b. the benefits that would be payable under all other Plans without applying Coordination of Benefits or similar provisions benefit;

The benefits described in a. of this section will be reduced. The sum of these reduced benefits plus all benefits payable for such Allowable Expenses under all other Plans will not exceed the total of the Allowable Expenses. When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against the benefit limits of This Plan.

Recovery of Excess Benefits
If 4 Ever Life pays Charges for benefits that should have been paid by the Primary Plan, or if 4 Ever Life pays Charges in excess of those for which We are obligated to provide under the Certificate, 4 Ever Life will have the right to recover the actual payment made or the Reasonable Cash Value of any services.

4 Ever Life will have sole discretion to seek such recovery from any person to, or for whom, or with respect to whom, such services were provided or such payments made by any insurance company, healthcare plan or other organization. If We request, You must execute and deliver to Us such instruments and documents as We determine are necessary to secure the right of recovery.

Right to Receive and Release Information
4 Ever Life, without consent or notice to You, may obtain information from and release information to any other Plan with respect to You in order to coordinate Your benefits pursuant to this section. You must provide Us with any information We request in order to coordinate Your benefits pursuant to this section. This request may occur in connection with a submitted claim; if so, You will be advised that the "other coverage" information, (including an Explanation of Benefits paid under the Primary Plan) is required before the claim will be processed for payment. If no response is received within 90 days of the request, the claim will be denied. If the requested information is subsequently received, the claim will be processed.

Medicare Eligible Insured Participants
Covered Persons eligible for Medicare receive the full benefits of this Plan, except for those Covered Persons listed below:

1. Covered Persons who are receiving treatment for end-stage renal disease following the first 30 months such Covered Persons are entitled to end-stage renal disease benefits under Medicare, regardless of group size.
2. Covered Persons who are entitled to Medicare benefits as disabled persons, unless the Covered Persons have a current employment status, as determined by Medicare rules, through a Group of 100 or more Employees (subject to COBRA legislation).
3. Covered Persons who are entitled to Medicare for any other reason, unless the Covered Persons have a current employment status, as determined by Medicare rules, through a Group of 20 or more Employees (subject to COBRA legislation).

In cases where exceptions 1, 2 or 3 apply, We will determine Our payment and then subtract the amount of benefits available from Medicare. We will pay the amount that remains after subtracting Medicare's payment. Please note, We will not pay any benefit when Medicare's payment is equal to or more than the amount which We would have paid in the absence of Medicare.

For example: Assume exception 1, 2 or 3 applies to the Covered Person, and he/she is billed for $100 of Covered Expense. And assume in the absence of Medicare, We would have paid $80. If Medicare pays $50, We would subtract that amount from the $80 and pay $30. However, if in this example, Medicare's payment is $80 or more, We will not pay a benefit.

Third Party Liability

This Plan does not cover:

- Expenses incurred by You or Your Dependent (individually and collectively referred to as a "Participant," in this section) for which another party may be responsible as a result of having caused or contributed to an Injury or Sickness.
- Expenses incurred by a Participant to the extent any payment is received for them either directly or indirectly from a third party tortfeasor or as a result of a settlement, judgment or arbitration award in connection with any automobile medical, automobile no-fault, uninsured or underinsured motorist, homeowners, workers' compensation, government insurance (other than Medicaid), or similar type of insurance or coverage.

Subrogation/Right of Reimbursement
If a Participant incurs a Covered Expense for which, in the opinion of the Plan or its claim Administrator, another party may be responsible or for which the Participant may receive payment as described above:

- Subrogation: The Plan shall, to the extent permitted by law, be subrogated to all rights, claims or interests that a Participant may have against such party and shall automatically have a lien upon the proceeds of any recovery by a Participant from such party to the extent of any benefits paid under the Plan. A Participant or his/her representative shall execute such documents as may be required to secure the Plan's subrogation rights.
- Right of Reimbursement: The Plan is also granted a right of reimbursement from the proceeds of any recovery whether by settlement, judgment, or otherwise. This right of reimbursement is cumulative with and not exclusive of the subrogation right granted in paragraph 1, but only to the extent of the benefits provided by the Plan.

Lien of the Plan
By accepting benefits under this Plan, a Participant:

- grants a lien and assigns to the Plan an amount equal to the benefits paid under the Plan against any recovery made by or on behalf of the Participant which is binding on any attorney or other party who represents the Participant whether or not an agent of the Participant or of any insurance company or other financially responsible party against whom a Participant may have a claim provided said attorney, insurance carrier or other party has been notified by the Plan or its agents;
- agrees that this lien shall constitute a charge against the proceeds of any recovery and the Plan shall be entitled to assert a security interest thereon;
- agrees to hold the proceeds of any recovery in trust for the benefit of the Plan to the extent of any payment made by the plan.

Additional Terms

- No adult Participant hereunder may assign any rights that it may have to recover medical expenses from any third party or other person or entity to any minor Dependent of said adult Participant without the prior express written consent of the Plan. The Plan's right to recover shall apply to decedents', minors', and incompetent or disabled persons' settlements or recoveries.
- No Participant shall make any settlement, which specifically reduces or excludes, or attempts to reduce or exclude, the benefits provided by the Plan.
- The Plan's right of recovery shall be a prior lien against any proceeds recovered by the Participant. This right of recovery shall not be defeated nor reduced by the application of any so-called "Made-Whole Doctrine", "Rimes Doctrine", or any other such doctrine purporting to defeat the Plan's recovery rights by allocating the proceeds exclusively to non-medical expense damages.
- No Participant hereunder shall incur any expenses on behalf of the Plan in pursuit of the Plan's rights hereunder, specifically; no court costs, attorneys' fees or other representatives' fees may be deducted from the plan's recovery without the prior express written consent of the Plan. This right shall not be defeated by any so-called "Fund Doctrine", "Common Fund Doctrine", or "Attorney's Fund Doctrine".
- The Plan shall recover the full amount of benefits provided hereunder without regard to any claim of fault on the part of any Participant, whether under comparative negligence or otherwise.
- In the event that a Participant shall fail or refuse to honor its obligations hereunder, then the Plan shall be entitled to recover any costs incurred in enforcing the terms hereof including, but not limited to, attorney's fees, litigation, court costs, and other expenses. The Plan shall also be entitled to offset the reimbursement obligation against any entitlement to future medical benefits hereunder until the Participant has fully complied with his reimbursement obligations hereunder, regardless of how those future medical benefits are incurred.
- Any reference to state law in any other provision of this Plan shall not be applicable to this provision, if the plan is governed by ERISA. By acceptance of benefits under the Plan, the Participant agrees that a breach hereof would cause irreparable and substantial harm and that no adequate remedy at law would exist. Further, the Plan shall be entitled to invoke such equitable remedies as may be necessary to enforce the terms of the Plan, including, but not limited to, specific performance, restitution, the imposition of an equitable lien and/or constructive trust, as well as injunctive relief.

Claim Process

Notice of Claim: Within twenty (20) days after a Covered Person receives covered services, or as soon as reasonably possible, he/she or someone on his/her behalf, must notify Us in writing of the claim.

Within fifteen (15) days after We receive the Covered Person's written notice of claim, We must:

a. acknowledge receipt of the claim;
b. begin any investigation of the claim;
c. specify the information the Covered Person must provide to file proof of loss. (We can request additional information during the investigation if necessary.)
d. send the Covered Person any forms We require for filing proof of loss. If We do not send the forms within this time period, the Covered Person can file proof of loss by giving Us a letter describing the occurrence, the nature and the extent of the Covered Person's claim. The Covered Person must give this letter within the time period for filing proof of loss.

Proof of Loss: Within ninety (90) days after the Covered Person receives covered services, he/she must send Us written proof of loss. If it is not reasonably possible to give Us written proof in the time required, We will not reduce or deny the claim for being late if the proof is filed as soon as reasonably possible. Unless the Covered Person is not legally capable, the required proof must always be given to Us no later than one calendar year from the date otherwise required.

All benefits payable under the Plan will be payable immediately upon receipt of written proof of such loss. Should We fail to pay the benefits payable under the Plan, We shall have fifteen (15) workings days thereafter within which to mail the Covered Person a letter or notice which states the reasons We may have for failing to pay the claim, either in whole or in part, and which also gives the Covered Person a written itemization of any documents or other information needed to process the claim or any portions thereof which are not being paid. When all of the listed documents or other information needed to process the claim has been received, We shall then have fifteen (15) working days within which to process and either pay the claim or deny it, in whole or in part, giving the Covered Person the reasons We may have for denying such claim or any portion thereof.

Subject to proof of loss, all accrued benefits payable under the Plan for loss of time will be paid not later than at the expiration of each period of thirty (30) days during the continuance of the period for which We are liable and any balance remaining unpaid at the termination of such period will be paid immediately upon receipt of such proof.

Time Payment of Claims: Benefits for a loss covered under this Plan will be paid as soon as We receive proper written proof of such loss. Any benefits payable to the Covered Person and unpaid at the Covered Person's death will be paid to the Covered Person's estate.

Payment of Claims: We may pay all or a portion of any indemnities provided for health care services to the participating health care services Provider, unless the Covered Person directs otherwise in writing by the time proofs of loss are filed. We will pay all or a portion of any indemnities provided for health care services by a nonparticipating health care services Provider directly to the Covered Person, unless the Covered Person directs otherwise in writing by the time proofs of loss are filed. We cannot require that the services be rendered by a particular health care services Provider.

Payment of Benefits – To Whom Payable: Medical Benefits are assignable to the Provider. When You assign benefits to a Provider, You have assigned the entire amount of the benefits due on that claim. If the Provider is overpaid because of accepting a Covered Person's payment on the charge, it is the Provider's responsibility to reimburse the Covered Person. Because of the contracts with Providers, all claims from contracted Providers should be assigned.

We may, at Our option, make payment to You for the cost of any Covered Expenses from a Non-Participating Provider even if benefits have been assigned. When benefits are paid to You or Your Dependent, You or Your Dependents are responsible for reimbursing the Provider.

If any person to whom benefits are payable is a minor or in Our opinion is not able to give a valid receipt for any payment due, such payment will be made to the legal guardian. If no request for payment has been made by the legal guardian, We may, at Our option, make payment to the person or institution appearing to have assumed custody and support.

When a Covered Person passes away, We may receive notice that an executor of the estate has been established. The executor has the same rights as a Covered Person and benefit payments for unassigned claims should be made payable to the executor.

Payment as described above will release Us from all liability to the extent of any payment made.

Payment to a Managing Conservator: Benefits paid on behalf of a covered Dependent child may be paid to a person who is not the insured Participant if an order issued by a court of competent jurisdiction in this or any other state names such person the managing conservator of the child.

To be entitled to receive benefits, a managing conservator of a child must submit to Us with the claim form, written notice that such person is the managing conservator of the child on whose behalf the claim is made and submit a certified copy of a court order establishing the person as managing conservator. This will not apply in the case of any unpaid medical bill for which a valid assignment of benefits has been exercised or to claims submitted by the insured Participant where the insured Participant has paid any portion of a medical bill that would be covered under the terms of the Plan.

Timely Filing of Claims: You should submit all claims within 180 days of the start of service or within thirty (30) days after the service is completed. We must receive claims:

- Within 365 days of discharge for Hospital or other medical facility expenses, or within 365 days of the date the expenses were incurred for any other services or supplies
- For Covered Persons who have Medicare, within 90 days of the process date shown on the Explanation of Medicare Benefits, whichever is greater

Misstatement of Age: If the age of a Covered Person has been misstated, an adjustment of premiums shall be made based on the Covered Person's true age. If age is a factor in determining eligibility or amount of insurance and there has been a misstatement of age, the insurance coverages or amounts of benefits, or both, shall be adjusted in accordance with the Covered Person's true age. Any such misstatement of age shall neither continue insurance otherwise validly terminated nor terminate insurance otherwise validly in force.

Plan Administrator In no event will We be the Plan Administrator for the purpose of compliance with the Consolidated Omnibus Budget Reconciliation Act (COBRA) or the Employee Retirement Income Security Act (ERISA). The term "Plan Administrator" refers either to the Group or to a person or entity other than Us, engaged by the Group to perform or assist in performing administrative tasks in connection with the Group's health Plan. The Group is responsible for satisfaction of notice, disclosure and other obligations of administrators under ERISA. In providing notices and otherwise performing under the Continuation (COBRA) section of this Certificate (if applicable), the Group is fulfilling statutory obligations imposed on it by federal law and, where applicable, acting as the Participant's agent.

Waiver of Rights: Failure by Us to enforce or require compliance with any provision herein will not waive, modify or render such provision unenforceable at any other time, whether the circumstances are or are not the same.

Physical Exam and Autopsy: We have the right to require a medical examination, at reasonable intervals, or an autopsy, where not prohibited by law, when a claim is made. If an examination or autopsy is required, the Covered Person will not have to pay for it.

Required Information: The Group will furnish Us all information necessary to calculate the Premium and all other information that We may require. Failure of the Group to furnish the information will not invalidate any insurance, nor will it continue any insurance beyond the last day of coverage. We have the right to examine any records of the Group, any person, company or organization which may affect the Premiums and benefits of the Plan. Our right to examine any records that exist:

- During the time the Plan is in force; or
- Until We pay the last claim.

We are not responsible for any claim for damages or injuries suffered by the Covered Person while receiving care in any Hospital, Ambulatory Surgical Center, Skilled Nursing Facility, or from any Participating or Non-Participating Provider. Such facilities and Providers act as independent contractors and not as Employees, agents or representatives of Us.

We are entitled to receive from any Provider of service information about the Covered Person which is necessary to administer claims on the Covered Person's behalf. This right is subject to all applicable confidentiality requirements. By submitting an application for coverage, the Covered Person has authorized every Provider furnishing care to disclose all facts pertaining to the Covered Person's and his/her insured Dependent's care, treatment, and physical condition, upon Our request. The Covered Person agrees to assist in obtaining this information if needed.

Right of Recovery
We have the right to recover amounts We paid that exceed the amount for which We are liable. Such amounts may be recovered from the Participant or any other payee, including a Provider. Or, such amounts may be deducted from future benefits of the Participant or any of his or her Dependents (even if the original payment was not made on that Covered Person's behalf) when the future benefits would otherwise have been paid directly to the subscriber or to a Provider that does not have a contract with Us.

In addition, if the Policy for this Plan is rescinded as described in "Intentionally False or Misleading Statements," We have the right to recover the amount of any claims We paid under this Plan and any administrative costs We incurred to pay those claims.

Other Provisions

Entire Contract and Changes: The entire contract between the Group and Us is as stated in the Policy and the entire contract between the Covered Person and Us is as stated in the Certificate of Coverage including the endorsements, application, and the attached papers, if any. No change in the Policy or Certificate of Coverage shall be effective until approved by one of Our officers. This approval must be noted on or attached to the Certificate of Coverage. No agent may change the Policy or waive any of its provisions.

Grace Period: There is a Grace Period of thirty-one (31) days allowed for the payment of each premium after the first premium, during which time the Policy continues in force.

Representations: All statements made by a Covered Person or the Group shall be considered representations and not warranties. We must provide the Covered Person or the Group with a copy of any statements used to contest coverage.

Time Limit on Certain Defenses/Misstatements on the Application: After two (2) calendar years from the effective date of the Policy, We will not contest the validity of the Policy. After two (2) calendar years from the Participant's effective date of coverage, no misstatements on the Participant's application may be used to:
a. void this coverage, or
b. deny any claim for loss incurred or disability that starts after the two (2) calendar year period.

The above does not apply to fraudulent misstatements.

Legal Actions: The Covered Person cannot file a lawsuit before sixty (60) days after We have been given written proof of loss. No action can be brought after three (3) calendar years from the time that proof is required to be given.

Conformity with State Statutes: If any provision of this Plan which, on its effective date, is in conflict with the statutes of the state in which the policyholder resides, it is amended to conform to the minimum requirements of those statutes.

Provision in Event of Partial Invalidity: If any provision or any word, term, clause, or part of any provision of this Plan shall be invalid for any reason, the same shall be ineffective, but the remainder of this Plan and of the provision shall not be affected and shall remain in full force and effect.

Alternate Cost Containment Provision: If it will result in less expensive treatment, We may approve services under an alternate treatment plan. An alternate treatment plan may include services or supplies otherwise limited or excluded by the Plan. It must be mutually agreed to by Us, the Covered Person, and the Covered Person's Physician, Provider, or other healthcare practitioner. Our offering an alternate treatment plan in a particular case in no way commits Us to do so in another case, nor does it prevent Us from strictly applying the express benefits, limitations, and exclusions of the Plan at any other time or for any other Covered Person.

IX. When You Have a Complaint or an Appeal

For the purposes of this section, any reference to "You", "Your" or "Covered Person" also refers to a representative or Provider designated by You to act on Your behalf, unless otherwise noted.

We want You to be completely satisfied with the care You receive. That is why We have established a process for addressing Your concerns and solving Your problems.

Start with Customer Services
We are here to listen and help. If You have a concern regarding a person, a service, the quality of care, or contractual benefits, You can call Our toll-free number and explain Your concern to one of Our Customer Service representatives. You can also express that concern in writing. Please write to Us at the following address:

Worldwide Insurance Services, LLC
Attn: Appeals Department
933 First Avenue
King of Prussia, PA 19406

We will do our best to resolve the matter on Your initial contact. If We need more time to review or investigate Your concern, We will get back to You as soon as possible, but in any case within 30 days.

If You are not satisfied with the results of a coverage decision, You can start the appeals procedure.

Appeals Procedure
4 Ever Life has a two-step appeals procedure for coverage decisions. To initiate an appeal, You must submit a request for an appeal in writing within 365 days of receipt of a denial notice. You should state the reason why You feel Your appeal should be approved and include any information supporting Your appeal. If You are unable or choose not to write, You may ask to register Your appeal by telephone. Call or write to Us at the toll-free number or address on Your Benefit Identification card, explanation of benefits or claim form.

Level One Appeal
Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional.

For level one appeals, We will respond in writing with a decision within fifteen calendar days after We receive an appeal for a required pre-service or concurrent care coverage determination (decision). We will respond within 30 calendar days after we receive an appeal for a post service coverage determination. If more time or information is needed to make the determination, We will notify You in writing to request an extension of up to 15 calendar days and to specify an additional information needed to complete the review.

You may request that the appeal process be expedited if, the time frames under this process would seriously jeopardize Your life, health or ability to regain maximum function or in the opinion of Your Physician would cause You severe pain which cannot be managed without the requested services; or Your appeal involves non-authorization of an admission or continuing Inpatient Hospital stay. 4 Ever Life's or its designee's Physician reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, We will respond orally with a decision within 72 hours, followed up in writing.

Level Two Appeal
If You are dissatisfied with our level one appeal decision, You may request a second review. To start a level two appeal, follow the same process required for a level one appeal.

Most requests for a second review will be conducted by the Appeals Committee, which consists of at least three people. Anyone involved in the prior decision may not vote on the Committee. For appeals involving Medical Necessity or clinical appropriateness, the Committee will consult with at least one Physician or Dentist reviewer in the same or similar specialty as the care under consideration, as determined by 4 Ever Life's or its designee's Physician or Dentist reviewer. You may present Your situation to the Committee by conference call.

For level two appeals We will acknowledge in writing that we have received Your request and schedule a Committee review. For required pre-service and concurrent care coverage determinations, the Committee review will be completed within 15 calendar days. For post-service claims, the Committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, We will notify You in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review. You will be notified in writing of the Committee's decision within five working days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage.

You may request that the appeal process be expedited if, the time frames under this process would seriously jeopardize Your life, health or ability to regain maximum function or in the opinion of Your Physician would cause You severe pain which cannot be managed without the requested services; or Your appeal involves non-authorization of an admission or continuing Inpatient Hospital stay. 4 Ever Life's or its designee's Physician reviewer, in consultation with the treating Physician will decide if an expedited appeal is necessary. When an appeal is expedited, We will respond orally with a decision within 72 hours, followed up in writing.

Independent Review Procedure
If You are not fully satisfied with the decision of 4 Ever Life's or its designee's level-two appeal review regarding Your Medical Necessity or clinical appropriateness issue, You may request that Your appeal be referred to an Independent Review Organization. The Independent Review Organization is composed of persons who are not employed by 4 Ever Life or Worldwide Insurance Services, LLC or any of its affiliates. A decision to use the voluntary level of appeal will not affect the claimant's rights to any other benefits under the Plan.

There is no charge for You to initiate this independent review process. 4 Ever Life will abide by the decision of the Independent Review Organization. In order to request a referral to an Independent Review Organization, certain conditions apply. The reason for the denial must be based on a Medical Necessity or clinical appropriateness determination by 4 Ever Life. Administrative, eligibility or benefit coverage limits or exclusions are not eligible for appeal under this process.

To request a review, You must notify the Appeals Coordinator within 180 days of Your receipt of 4 Ever Life's or its designee's level-two appeal review denial. 4 Ever Life will then forward the file to the Independent Review Organization.

The Independent Review Organization will render an opinion within 30 days. When requested and when a delay would be detrimental to Your condition, as determined by 4 Ever Life's or its designee's Physician reviewer, the review shall be completed within 3 days.

The Independent Review Program is a voluntary program arranged by 4 Ever Life.

Appeal to the State of Delaware
You have the right to appeal a claim denial for medical reasons or to appeal a claim denial for non-medical reasons to the Delaware Insurance Department. The Delaware Insurance Department also provides free informal mediation services which are in addition to, but do not replace, Your right to appeal this decision. You can contact the Delaware Insurance Department for information about an appeal or mediation by calling the Consumer Services Division at (302) 674-7310. You may go to the Delaware Insurance Department at The Rodney Building, 841 Silver Lake Blvd., Dover, DE 19904 between the hours of 8:30 a.m. and 4:00 p.m. to personally discuss the appeal or mediation process. You may also wish to submit a complaint by sending an e-mail to the Delaware Insurance Department at consumer@deins.state.de.us, or by using the complaint form, found at http://www.delawareinsurance.gov/complaint/complaintform. You also can pdf and fax the complaint to (302) 739-6278.

All appeals must be filed within 60 days from the date You receive this notice otherwise this decision will be final.

Notice of Benefit Determination on Appeal
Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: the specific reason or reasons for the adverse determination; reference to the specific Plan provisions on which the determination is based; a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; a statement describing any voluntary appeal procedures offered by the Plan and the claimant's right to bring an action under ERISA section 502(a); upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding Your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, Experimental treatment or other similar exclusion or limit.

You also have the right to bring a civil action under Section 502(a) of ERISA if You are not satisfied with the decision on review. You or Your Plan may have other voluntary alternative dispute resolution options such as mediation. One way to find out what may be available is to contact Your local U.S. Department of Labor office and Your State insurance regulatory agency. You may also contact the Plan Administrator.

Relevant Information
Relevant Information is any document, record, or other information which was relied upon in making the benefit determination; was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit or the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Legal Action
If Your Plan is governed by ERISA, You have the right to bring a civil action under Section 502(a) of ERISA if You are not satisfied with the outcome of the Appeals Procedure. In most instances, You may not initiate a legal action against Us until You have completed the Level One and Level Two Appeal processes. If Your Appeal is expedited, there is no need to complete the Level Two process prior to bringing legal action.

Notice of an Appeal or a Grievance
The appeal or grievance provision in this Certificate may be superseded by the law of Your state. Please see Your explanation of benefits for the applicable appeal or grievance procedure.

X. Definitions

Active Service
You will be considered in Active Service:
- on any of the Employer's scheduled work days if You are performing the regular duties of Your work on that day either at the Employer's place of business or at some location to which You are required to travel for Your Employer's business.
- on a day which is not one of Your Employer's scheduled work days if You were in Active Service on the preceding scheduled work day.

Bed and Board
The term Bed and Board includes all Charges made by a Hospital on its own behalf for room and meals and for all general services and activities needed for the care of registered bed patients.

Certificate or Certificate of Coverage
This term means this document, the Schedule of Benefits, including Your application for coverage under Our benefit program described in this document.

Certification
The term Certification means a decision by a health care insurer that a health care service requested by a Provider or covered person has been reviewed and, based upon the information available, meets the health care insurer's requirements for coverage and Medical Necessity, and the requested health care service is therefore approved.

Charges
The term Charges means the actual billed Charges; except when the Provider has contracted directly or indirectly with Us for a different amount.

Chiropractic Care
The term Chiropractic Care means the conservative management of neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain and improve function.

Covered Expense(s)
Covered Expenses are the expenses incurred for covered services. Covered Expenses may be limited by other specific maximums described in the Schedule of Benefits, and other sections of this Certificate. Covered Expenses are subject to applicable Deductible, Copayments and coinsurance that may be imposed as specified in the Schedule of Benefits. For non-Participating Providers, only those parts of a charge that are less than or equal to the Maximum Reimbursable Charge are Covered Expenses. An expense is incurred on the date the Covered Person receives the service or supply.

Covered Person
Covered Person means an eligible Participant and any eligible Dependents enrolled in this Plan and for which the Covered Person is entitled to receive benefits.

Custodial Care
Services and supplies that are primarily intended to help You meet personal needs. Custodial Care can be prescribed by a Physician or given by trained medical personnel. It may involve artificial methods such as feeding tubes, ventilators or catheters. Examples of Custodial Care include:
- Routine patient care such as changing dressings, periodic turning and positioning in bed, administering medications;
- Care of a stable tracheostomy (including intermittent suctioning);
- Care of a stable colostomy/ileostomy;
- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings;
- Care of a stable indwelling bladder catheter (including emptying/changing containers and clamping tubing);
- Watching or protecting You;
- Respite care, adult (or child) day care, or convalescent care;
- Institutional care, including Bed and Board for rest cures, adult day care and convalescent care;
- Help with the daily living activities, such as walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating or preparing foods;
- Any services that a person without medical or paramedical training could be trained to perform; and
- Any service that can be performed by a person without any medical or paramedical training.

Dentist
The term Dentist means a person practicing dentistry or oral surgery within the scope of his license. It will also include a Physician operating within the scope of his license when he performs any of the Dental Services described in the Certificate of Coverage.

Dependent
Dependents are:

- Your lawful spouse or domestic partner; and
- any child of Yours who is:
  - less than 26 years old.
  - 26 or more years old, unmarried and primarily supported by You and incapable of self-sustaining employment by reason of mental or physical disability which arose while the child was covered as a Dependent under this Plan, or while covered as a Dependent under a prior plan with no break in coverage.
  - Proof of the child's condition and dependence must be submitted to the Plan within 31 days after the date the child ceases to qualify above. From time to time, but not more frequently than once a year, the Plan may require proof of the continuation of such condition and dependence.

The term child means a child born to You or a child legally adopted by You or placed with You for adoption. It also includes a stepchild.

Benefits for a Dependent child will continue until the last day of the calendar month in which the limiting age is reached.

Anyone who is eligible as a primary Participant will not be considered as a Dependent spouse. A child under age 26 may be covered as either a primary Participant or as a Dependent child. You cannot be covered as a primary Participant while also covered as a Dependent of a Participant.

No one may be considered as a Dependent of more than one Participant.

Doula
Is a certified or licensed care-giver in the country of their practice of non-medical support to women and their families during labor and childbirth, and also the postpartum period.

Emergency Medical Condition
Emergency Medical Condition means a medical condition which manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

Emergency Services
Emergency Services means, with respect to an Emergency Medical Condition, a medical screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate the Emergency Medical Condition; and such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, to Stabilize the patient.

Employee
The term Employee means a full-time employee of the Employer who is currently in Active Service who usually works at least 30 hours a week in the conduct of the Group's business. The term does not include Employees who normally work less than 30 hours a week for the Employer. An Employee does not include an employee who works on a part-time, temporary, or substitute basis.

Employer
The term Employer means a Group participating under the Policy and all affiliated Employers.

Essential Health Benefits
Essential Health Benefits means, to the extent covered under the Plan, expenses incurred with respect to covered services, in at least the following categories: ambulatory patient services, Emergency Services, Hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, Prescription Drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management and pediatric services, including oral and vision care.

Expense Incurred
An expense is incurred when the service or the supply for which it is incurred is provided.

Experimental/Investigational
Experimental/Investigational means treatment, a device or prescription medication which is recommended by a Physician, but is not considered by the medical community as a whole to be safe and effective for the condition for which the treatment, device or prescription medication is being used, including any treatment, procedure, facility, equipment, drugs, drug usage, devices, or supplies not recognized as accepted medical practice; and any of those items requiring federal or other governmental agency approval not received at the time services are rendered. We will make the final determination as to what is Experimental or Investigational. Experimental/Investigational does not include the routine medical costs associated with clinical trials.

Free-Standing Surgical Facility
The term Free-standing Surgical Facility means an institution which meets all of the following requirements:
- it has a medical staff of Physicians, Nurses and licensed anesthesiologists;
- it maintains at least two operating rooms and one recovery room;
- it maintains diagnostic laboratory and X-ray facilities;
- it has equipment for emergency care;
- it has a blood supply;
- it maintains medical records;
- it has agreements with Hospitals for immediate acceptance of patients who need Hospital Confinement on an Inpatient basis; and
- it is licensed in accordance with the laws of the appropriate legally authorized agency.

Group
Group refers to the Employer or entity participating under the Policy which We have issued.

Group Policy or Policy
Group Policy means the agreement between Us and the Group, any riders, this Certificate, the Schedule of Benefits, the Benefit Program Application and any employee application form of the persons covered under the Policy.

Home Country
Home Country means the Covered Person's country of domicile named on the enrollment form or the roster, as applicable. However, the Home Country of an eligible Dependent who is a child is the same as that of the eligible Participant.

Home Health Care Services
Home Health Care Services means those services and supplies from a Provider, approved by Us that is engaged in providing, either directly or through an arrangement, health care or skilled nursing services on an intermittent basis in the patient's home in accordance with an approved Home Health Care treatment Plan.

Hospice Care Program
The term Hospice Care Program means:
- a coordinated, interdisciplinary program to meet the physical, psychological, spiritual and social needs of dying persons and their families;
- a program that provides palliative and supportive medical, nursing and other health services through home or Inpatient care during the Sickness;
- a program for persons who have a Terminal Illness and for the families of those persons.

Hospice Care Services
The term Hospice Care Services means any services provided by: a Hospital, a Skilled Nursing Facility or a similar institution, a Home Health Care Agency, a Hospice Facility, or any other licensed facility or agency under a Hospice Care Program.

Hospice Facility
The term Hospice Facility means an institution or part of it which:
- primarily provides care for Terminally Ill patients;
- is accredited by the National Hospice Organization;
- meets standards established by Us; and
- fulfills any licensing requirements of the state or locality in which it operates.

Hospital
The term Hospital means:
- an institution licensed as a Hospital, which: maintains, on the premises, all facilities necessary for medical and surgical treatment; provides such treatment on an Inpatient basis, for compensation, under the supervision of Physicians; and provides 24-hour service by Registered Graduate Nurses;
- an institution which qualifies as a Hospital, a psychiatric Hospital or a tuberculosis Hospital, and a Provider of services under Medicare, if such institution is accredited as a Hospital by the Joint Commission on the Accreditation of Healthcare Organizations; or
- an institution which: specializes in treatment of Mental Health and Substance Abuse or other related Sickness; provides residential treatment programs; and is licensed in accordance with the laws of the appropriate legally authorized agency.

The term Hospital will not include an institution which is primarily a place for rest, a place for the aged, or a nursing home.

Hospital Confinement or Confined in a Hospital
A person will be considered Confined in a Hospital if he is:
- A registered bed patient in a Hospital upon the recommendation of a Physician;
- Receiving treatment for Mental Health and Substance Abuse Services in a Partial Hospitalization program;
- Receiving treatment for Mental Health and Substance Abuse Services in a Mental Health or Substance Abuse Residential Treatment Center.

Infertile or Infertility
The condition of a presumably healthy covered person who is unable to conceive or produce conception after:
- For a woman who is under 35 years of age: one year or more of timed, unprotected coitus, or 12 cycles of artificial insemination; or
- For a woman who is 35 years of age or older: six months or more of timed, unprotected coitus, or six cycles of artificial insemination.

Injury
The term Injury means an accidental bodily Injury.

Inpatient
An Inpatient Admission means a Covered Persons actual entry into a Hospital, extended care facility, or facility Provider to receive Inpatient services as a registered bed patient in such Hospital, extended care facility, or facility Provider and for whom a Bed and Board charge is made; the Inpatient stay shall continue until such time as the Covered Person is actually discharged from the facility.

Insurer
Means 4 Ever Life Insurance Company.

International
Means any country or territory other than the United States of America, the District of Columbia, the U.S. Virgin Islands or Puerto Rico.

Maximum Reimbursable Charge
The Maximum Reimbursable Charge for covered services is determined based on the lesser of:
- the Provider's normal charge for a similar service or supply; or
- an Insurer-selected percentile of Charges made by Providers of such service or supply in the geographic area where it is received as compiled in a database selected by Us or Our designee.

The percentile used to determine the Maximum Reimbursable Charge is listed in The Schedule.

The Maximum Reimbursable Charge is subject to all other benefit limitations and applicable coding and payment methodologies determined by Us. Additional information about how We determine the Maximum Reimbursable Charge is available upon request.

Medicaid
The term Medicaid means a state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965 as amended.

Medically Necessary/Medical Necessity
Medically Necessary covered services and supplies are those determined by the Medical Director to be:
- required to diagnose or treat an illness, Injury, disease or its symptoms;
- in accordance with generally accepted standards of medical practice;
- clinically appropriate in terms of type, frequency, extent, site and duration;
- not primarily for the convenience of the patient, Physician or other health care Provider; and
- rendered in the least intensive setting that is appropriate for the delivery of the services and supplies. Where applicable, the Medical Director may compare the cost-effectiveness of alternative services, settings or supplies when determining least intensive setting.

Medicare
The term Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965 as amended.

Morbid Obesity
This means:
- Your body mass index (BMI) exceeds 40; or
- Your BMI exceeds 35 and You have one of the following conditions:
  - Coronary heart disease; or
  - Type 2 diabetes mellitus; or
  - Clinically significant obstructive sleep apnea; or
  - Medically refractory hypertension (blood pressure greater than 140 mmHg systolic and/or 90 mmHg diastolic, despite optimal medical management).

Necessary Services and Supplies
The term Necessary Services and Supplies includes any Charges, except Charges for Bed and Board, made by a Hospital on its own behalf for medical services and supplies actually used during Hospital Confinement, any Charges, by whomever made, for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided; and any Charges, by whomever made, for the administration of anesthetics during Hospital Confinement. The term Necessary Services and Supplies will not include any Charges for special nursing fees, dental fees or medical fees.

Nurse
The term Nurse means a Registered Graduate Nurse, a Licensed Practical Nurse or a Licensed Vocational Nurse who has the right to use the abbreviation "R.N.," "L.P.N." or "L.V.N."

Ophthalmologist
The term Ophthalmologist means a person practicing ophthalmology within the scope of his license. It will also include a Physician operating within the scope of his license when he performs any of the Vision Care services described in the Certificate of Coverage.

Optician
The term Optician means a fabricator and dispenser of eyeglasses and/or contact lenses. An Optician fills prescriptions for glasses and other optical aids as specified by Optometrists or Ophthalmologists. The state in which an Optician practices may or may not require licensure for rendering of these services.

Optometrist
The term Optometrist means a person practicing optometry within the scope of his license. It will also include a Physician operating within the scope of his license when he performs any of the Vision Care services described in the Certificate of Coverage.

Other Health Care Facility/Other Participating Health Professional
A person who is in a Provider category licensed to practice health care related services consistent with the laws in jurisdiction in which the services are performed. Such persons are considered health care Providers only to the extent services are covered by the provisions of this Plan. Also included is an employee or agent of such a person, acting in the course of and within the scope of his or her employment.

Providers also include certain Health Care Facilities and other Providers of health care services and supplies, as specifically indicated in the Provider category listing below.

Covered licensed or certified categories of Providers, will include the following, provided that the services they furnish are consistent with state law, and the conditions of coverage described elsewhere in this Plan are met:

- Acupuncturists (L.Ac.), also called East Asian Medicine Practitioners (E.A.M.P.)
- Audiologists
- Chiropractors (D.C.)
- Counselors
- Dentists (D.D.S. or D.M.D.)
- Denturists
- Dietitians and Nutritionists (D. or C.D., or C.N.)
- Home Health Care, Hospice and Home Care Agencies
- Marriage and Family Therapists
- Massage Practitioners (L.M.P.)
- Midwives
- Naturopathic Physicians (N.D.)
- Nurses (R.N., L.P.N., A.R.N.P., or N.P.)
- Nursing Homes
- Occupational Therapists (O.T.A.)
- Ocularists
- Opticians (Dispensing)
- Optometrists (O.D.)
- Osteopathic Physician Assistants (O.P.A.) (under the supervision of a D.O.)
- Osteopathic Physicians (D.O.)
- Pharmacists (R.Ph.)
- Physical Therapists (L.P.T.)
- Physician Assistants (under the supervision of an M.D.)
- Physicians (M.D.)
- Podiatric Physicians (D.P.M.)
- Psychologists
- Radiologic Technologists (C.R.T., C.R.T.T., C.R.D.T., C.N.M.T.)
- Respiratory Care Practitioners
- Social Workers
- Speech-Language Pathologists

The following Health Care Facilities and other Providers of health care services and supplies will be considered health care Providers for the purposes of this Plan, as long as they are licensed or certified by the State (unless otherwise stated) that the services they furnish are consistent with state law and the conditions of coverage described elsewhere in this Plan are met:

- Ambulance Companies
- Ambulatory Diagnostic, Treatment and Surgical Facilities
- Audiologists (CCC-A or CCC-MSPA)
- Birthing Centers
- Blood Banks
- Community Mental Health Centers
- Drug and Alcohol Treatment Facilities
- Medical Equipment Suppliers
- Hospitals
- Kidney Disease Treatment Centers (Medicare-certified)
- Psychiatric Hospitals
- Speech Therapists (Certified by the American Speech, Language and Hearing Association)

Note: Outside of the United States, a Provider is a medical professional service Provider providing services within the scope of their license as determined by the local jurisdiction in which they are practicing.

Outpatient
Outpatient means medical, nursing, counseling or therapeutic treatment provided to a Participant who does not require an overnight stay in a Hospital or other Inpatient facility.

Participant
An enrolled Employee of the Group. Coverage under this Plan is established in the Participant's name.

Participating Provider
The term Participating Provider means a Hospital, a Physician or any other health care practitioner or entity that has a direct or indirect contractual arrangement with Us or Our designee to provide covered services with regard to a particular Plan under which the Participant is covered.

Physician
The term Physician means a licensed medical practitioner who is practicing within the scope of his license and who is licensed to prescribe and administer drugs or to perform surgery. It will also include any other licensed medical practitioner whose services are required to be covered by law in the locality where the Policy is issued if he is:

- operating within the scope of his license; and
- performing a service for which benefits are provided under this Plan when performed by a Physician.

In addition, professional services provided by one of the following types of Providers will be covered under this Plan, but only when the Provider is providing a service within the scope of his or her state license; providing a service or supply for which benefits are specified in this Plan; and providing a service for which benefits would be payable if the service were provided by a Physician as defined above:

- Chiropractor (D.C.)
- Dentist (D.D.S. or D.M.D.)
- Optometrist (O.D.)
- Podiatrist (D.P.M.)
- Psychologist (Ph.D.)
- Nurse (R.N.)

Note: Outside of the United States, a Physician is a medical professional service Provider providing services within the scope of their license as determined by the local jurisdiction in which they are practicing.

Plan
Plan means the set of benefits described in the Certificate of Coverage booklet and in the amendments to this Certificate (if any). This Plan is subject to the terms and conditions of the Policy We have issued to the Group. If changes are made to the Policy or Plan, an amendment or revised Certificate will be issued to the Group for distribution to each Participant affected by the change.

Policy
Policy is the Group Policy We have issued to the Group.

Policy Year
The period of 12 consecutive months commencing with the Effective Date of the insurance contract or with an anniversary of that date.

Prescription Drug
Prescription Drug means; a drug which has been approved by the Food and Drug Administration (FDA) for safety and efficacy; certain drugs approved under the FDA's Drug Efficacy Study Implementation review; or drugs marketed prior to 1938 and not subject to review, and which can, under federal or state law, be dispensed only pursuant to a Prescription Order.

Prescription Drug List
Prescription Drug List means a listing of approved Prescription Drugs and Related Supplies. The Prescription Drugs and Related Supplies included in the Prescription Drug List have been approved in accordance with parameters established by the Pharmacy & Therapeutics (P&T) Committee. The Prescription Drug List is regularly reviewed and updated.

Prescription Order
Prescription Order means the lawful authorization for a Prescription Drug or Related Supply by a Physician who is duly licensed to make such authorization within the course of such Physician's professional practice or each authorized refill thereof.

Preventive Treatment
The term Preventive Treatment means treatment rendered to prevent disease or its recurrence.

Primary Care Physician
Is a Physician who supervises, coordinates and provides initial care and basic medical services to a person as a general or family care practitioner, or in some cases, as an internist or a pediatrician.

Provider
Any health care institution, practitioner, or group of practitioners that are licensed to render health care services including, but not limited to: a Physician, a group of Physicians, allied health professional, certified midwife, Hospital, Skilled Nursing Facility, rehabilitation Hospital, birthing facility, or home health Provider.

Psychologist
The term Psychologist means a person who is licensed or certified as a clinical Psychologist. Where no licensure or certification exists, the term Psychologist means a person who is considered qualified as a clinical Psychologist by a recognized psychological association. It will also include any other licensed counseling practitioner whose services are required to be covered by law in the locality where the Policy is issued if he is operating within the scope of his license and performing a service for which benefits are provided under this Plan when performed by a Psychologist.

Related Supplies
Related Supplies means diabetic supplies (insulin needles and syringes, lancets and glucose test strips), needles and syringes for injectables covered under the pharmacy plan, and spacers for use with oral inhalers.

Review Organization
The term Review Organization refers to an affiliate of Ours or another entity to which We have delegated responsibility for performing utilization review services. The Review Organization is an organization with a staff of clinicians which may include Physicians, Registered Graduate Nurses, licensed mental health and substance abuse professionals, and other trained staff members who perform utilization review services.

Sickness – For Medical Insurance
The term Sickness means a physical or mental illness. It also includes pregnancy. Expenses incurred for routine Hospital and pediatric care of a newborn child prior to discharge from the Hospital nursery will be considered to be incurred as a result of Sickness.

Skilled Nursing Facility
The term Skilled Nursing Facility means a licensed institution (other than a Hospital, as defined) which specializes in:

- physical rehabilitation on an Inpatient basis; or
- skilled nursing and medical care on an Inpatient basis;
  but only if that institution: maintains on the premises all facilities necessary for medical treatment; provides such treatment, for compensation, under the supervision of Physicians; and provides Nurses' services.

Specialist
A Physician who practices in any generally accepted medical or surgical sub-specialty. Examples include Ob/Gyne, surgeons, cardiologists, urologists, dermatologists.

Stabilize
Stabilize means, with respect to an Emergency Medical Condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

Terminal Illness
A Terminal Illness will be considered to exist if a person becomes terminally ill with a prognosis of six months or less to live, as diagnosed by a Physician.

Telehealth
Telehealth means the mode of delivering health care or other health service via information and communication technologies to facilitate the diagnosis, consultation and treatment, education, care management and self-management of a patient's physical and mental health.

Totally Disabled
With respect to a Participant, an inability by reason of illness, Injury or physical condition to perform the material duties of any occupation for which the Participant is or becomes qualified by reason of experience, education or training or with respect to a covered person other than a Participant, the inability by reason of illness, Injury or physical condition to engage in the normal activities of a person of the same age and sex who is in good health. The Totally Disabled person must be under the regular care of a Physician.

Urgent Care
Urgent Care is medical, surgical, Hospital or related health care services and testing which are not Emergency Services, but which are determined by Us, in accordance with generally accepted medical standards, to have been necessary to treat a condition requiring prompt medical attention. This does not include care that could have been foreseen before leaving the immediate area where You ordinarily receive and/or were scheduled to receive services. Such care includes, but is not limited to, dialysis, scheduled medical treatments or therapy, or care received after a Physician's recommendation that the insured should not travel due to any medical condition.

U.S.
Means the United States of America, including the District of Columbia, the U.S. Virgin Islands and Puerto Rico.

We, Us and Our
Means 4 Ever Life Insurance Company.

You, Your
Means an eligible Participant or eligible Dependent.

4 EVER LIFE INSURANCE COMPANY
Oakbrook Terrace, Illinois 60181

Administrative Office:
GeoBlue®
c/o Worldwide Insurance Services, LLC
933 First Avenue
King of Prussia, PA 19406

Dental Services Rider

The Covered Services under this dental rider are classified as Diagnostic and Preventive, Basic, Major, and Orthodontic services. The lists of services that relate to each type are outlined in the following pages under "Description of Covered Services". These services are covered once all of the following requirements are met. It is important to understand all of these requirements so You can make the most of Your dental benefits.

Benefits are available for the services described in this Plan that are furnished for a covered dental condition. Such services must meet all of the following requirements:

- They must be Dentally Necessary (see definition of "Dentally Necessary");
- They must be named in this Plan as covered;
- They must be furnished by a licensed Dentist (D.M.D. or D.D.S.) or denturist. Services may also be provided by a dental hygienist under the supervision of a licensed dentist, or other individual, performing within the scope of his or her license or certification, as allowed by law. (These providers are referred to as "Dental Care Providers."); and
- They must not be excluded from coverage under this benefit

At times We may need to review diagnostic materials such as dental X-rays to determine Your available benefits. These materials will be requested directly from Your Dental Care Provider. If We are unable to obtain necessary materials, the Plan will provide benefits only for those dental services We can verify as covered.

Alternative Benefits

To determine benefits available under this Plan, We consider alternative procedures or services with different fees that are consistent with acceptable standards of dental practice. In all cases where there is an alternative course of treatment that is less costly, the Plan will only provide benefits for the treatment with the lesser fee. If You and Your Dental Care Provider choose a more costly treatment, You are responsible for the additional charges beyond those for the less costly alternative treatment.

Requesting An Estimate Of Benefits

An estimate of benefits verifies, for the Dental Care Provider and You, Your eligibility and benefits. Because We consider alternative treatment at the time We review the estimate, Our review may result in a lower cost of treatment and additional services under this benefit. It may also clarify, before services are rendered, treatment that is not covered in whole or in part. This can protect You from unexpected out-of-pocket expenses.

An estimate of benefits is not required in order for You to receive Your dental benefits. However, We suggest that Your Dental Care Provider submit an estimate to Us for any proposed dental services in which You are concerned about Your out-of-pocket expenses.

Our estimate of benefits should not be considered a guarantee of payment. Payment of any service will be based on Your eligibility and benefits available at the time services are rendered.

Coinsurance

As used in this Plan, "Coinsurance" is a defined percentage of charges for Covered Services and supplies You receive. The percentage You are responsible for is called "Coinsurance."

Deductibles

Deductibles are expenses to be paid by You or Your Dependent. Deductibles are in addition to any Coinsurance. Once the Deductible maximum in the Schedule of Benefits has been reached You and Your family need not satisfy any further dental Deductible for the rest of that year.

WHAT ARE MY BENEFITS?

Dental Benefit Maximum

The maximum amount of dental benefits available to any one Covered Person is shown below.

• Policy Year Maximum Combined Benefit for Diagnostic and Preventive Service, Basic Services and Major Services	$2,000
• Orthodontic Lifetime Maximum	$1,500
• Per Person Policy Year Dental Deductible *Not applicable to Diagnostic and Preventive Services* • Family Maximum	$50 $150
• Per Person Policy Year Orthodontic Deductible	$0

Benefits for Covered Services with multiple treatment dates are subject to the dental benefit maximum of the Policy Year in which the services are started.

However, if You receive dental implant services, the post insertion and the final crown or bridgework will be considered to be separate services, and those services will be calculated under the Policy Year limitation in which they are received.

Providers

The Dental Benefits offered includes Participating and non- Participating Providers. This Plan is designed to cover all Dental Care Providers at the same benefit level.

You may be required to submit the dental claim Yourself if Your Dental Care Provider does not do this for You. Please see the "How Do I File A Claim?" section in this booklet for instructions on submitting claims for reimbursement.

Benefit Percentages

After You satisfy the required Policy Year Deductible if one applies, You pay the following Coinsurance per Policy Year, up to the dental benefit maximum. Dental services fall into 4 categories: Diagnostic and Preventive services, Basic services, Major services and Orthodontic services. In this section You will find a description of the services included in each category.

• Diagnostic and Preventive Services	0%
• Basic Services	20%
• Major Services	50%
• Orthodontic Services	50%

Description of Covered Services

Covered Services

The following section lists covered dental services. We may agree to cover expenses for a service not listed. To be considered, the service should be identified using the American Dental Association Uniform Code of Dental Procedures and Nomenclature, or by description and then submitted to Us.

Diagnostic and Preventive Services

- Routine oral examinations are limited to 2 per Policy Year. Initial consultations, second opinion consultations and office visits count toward the limit for oral examinations;
- Emergency oral examinations. (Please see the "Definitions" section for the definition of a Dental Emergency.) Services that are determined to be routine will be limited to 2 per Policy Year;
- Prophylaxis (cleaning, scaling, and polishing of teeth) is limited to 2 per Policy Year;
- Topical application of fluoride is covered for Covered Persons under the age of 20. They are limited to 2 treatments per Policy Year;
- X-rays – Complete series or Panoramic (Panorex) – Only one per person, including panoramic film, in any 36 consecutive months;
- Bitewing X-rays – Only 2 charges per person per Policy Year;
- Space maintainers, for Covered Persons under the age of 20;
- Sealants, for Covered Persons under the age of 19, are limited to use on permanent teeth; and
- Oral pathology laboratory services, not including the removal of tissue sample, is covered when directly related to teeth and gums.

Basic Services

- Simple extractions;
- Oral surgery consisting of surgical extractions, fracture and dislocation treatment, and diagnosis and treatment of cysts and abscesses;
- Dentally Necessary injectable drugs administered in a dental office;
- Fillings, consisting of amalgam and composite resins on any given tooth surface are covered once in any 24 consecutive months. Resin based composite fillings performed on second and third molars are considered cosmetic and will be reduced to the amalgam allowance;
- Stainless steel crowns are limited to one per tooth every 2 Policy Years;
- Non-surgical treatment of periodontal and other diseases of the gums and tissues of the mouth;
- Periodontal scaling and root planing and sub-gingival curettage is limited to a total of 2 full-mouth treatments in any 12 consecutive months;
- Periodontal maintenance, as a follow-up to active periodontal treatment, including removal of bacterial flora, sub-gingival scaling, polishing, periodontal evaluation and review of oral hygiene, is limited to 4 visits per Policy Year;
- Repair and re-cementing of crowns, inlays, bridgework and dentures;
- Emergency palliative treatment. We require a written description and/or office records of services provided;
- General anesthesia in a Dental Care Provider's office, when Dentally Necessary. This includes Covered Persons who are under the age of 7 or are disabled physically or developmentally;
- Osseous surgery, which includes gingivectomy, gingivoplasty, and gingival flap procedures;
- Endodontic (root canal) treatment;
- Benefits for root canals performed in conjunction with over-dentures are limited to 2 per arch;
- Open and drain (open and broach) (open and medicate) procedures may be limited to a combined allowance based on Our review of the services rendered; and
- X-rays done in conjunction with a root canal. The primary periapical x-ray for diagnostic purposes is covered. Additional X-rays are limited to the allowance for the root canal therapy.

Major Services

- Initial placement of inlays, onlays, laboratory-processed labial veneers, and crowns for decayed or fractured teeth when amalgam or composite resin fillings would not adequately restore the teeth;
- Replacement inlays, onlays, laboratory-processed labial veneers and crowns, but only when:
  - The existing restoration was seated at least 5 years before replacement; or
  - The service is a result of an Injury as described under "Dental Care Services For Injuries";
- Occlusal guards, for bruxism (grinding) only. Limited to 1 every 3 rolling years;
- Initial placement of dentures;
- Initial placement of fixed bridgework (including inlays, onlays and crowns to form abutments);
- Replacement dentures and fixed bridgework, but only when:
  - The existing denture or bridgework was installed at least 5 years before replacement;
  - The replacement or addition of teeth is required to replace 1 or more additional teeth extracted after initial placement; or
  - Re-preparation of the natural tooth structure under the existing fixed bridgework is required as a result of an Injury to that structure, and such repair is performed within 12 months of the injury as described under "Dental Care Services For Injuries";
- Relining and rebasing of dentures when performed 6 or more months after denture installation. Charges for relines, rebases and adjustments performed during the first 6 months following denture installation are limited to the allowance for the denture;
- Tooth build-ups for covered onlays and crowns, including bridge abutments;
- Implants and implant-related services;
  Note: Covered services including implant abutment and/or crowns over the implants are covered only once in a 5-consecutive year period (5 years from the date of the installation of the prosthetic service).
- Precision attachments.

Orthodontic Services

Orthodontic treatment is the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies. Dentally Necessary orthodontic care can be beneficial to generally prevent disease and promote oral health. To be considered Dentally Necessary orthodontic care, at least one of the following must be present:

- There is spacing between adjacent teeth which interferes with the biting function;
- There is an overbite to the extent that the lower anterior teeth impinge on the roof of the mouth when You bite;
- Positioning of the jaws or teeth impair chewing or biting function;
- On an objective professionally recognized dental orthodontic severity index, the condition scores at a level consistent with the need for orthodontic care; or
- Based on a comparable assessment of items (a) through (d) above, there is an overall orthodontic problem that interferes with the biting function.

You or Your orthodontist should send Your treatment plan to Us to find out if it will be covered under this Plan.

Benefits may include the following:

- Limited treatment. Treatments which are not full treatment cases and are usually done for minor tooth movement;
- Interceptive treatment. A limited (phase I) treatment phase used to prevent or assist in the severity of future treatment;
- Comprehensive (complete) treatment. Full treatment includes all radiographs, diagnostic casts or models, appliances and visits;
- Removable appliance therapy. An appliance that is removable and not cemented or bonded to the teeth;
- Fixed appliance therapy. A component that is cemented or bonded to the teeth; and
- Other complex surgical procedures. Surgical exposure of impacted or un-erupted tooth for orthodontic reasons or surgical repositioning of teeth.

Treatment that is already in progress with appliances placed before You were covered by this Plan will be covered on a pro-rated basis.

Benefits do not include:

- Monthly treatment visits that are inclusive of treatment cost;
- Repair or replacement of lost/broken/stolen appliances;
- Orthodontic retention/retainer as a separate service;
- Retreatment and/or services for any treatment due to relapse;
- Inpatient or Outpatient Hospital expenses (please refer to Your medical coverage to determine if this is a covered medical service); and
- Provisional splinting, temporary procedures or interim stabilization of teeth.

Orthodontic payments: Because orthodontic treatment normally occurs over a long period of time, benefit payments are made over the course of treatment. You must continue to be eligible under the Plan in order to receive ongoing payments for Your orthodontic treatment.

Payments for treatment are made: (1) when treatment begins (appliances are installed), and (2) at six month intervals thereafter, until treatment is completed or this Plan's coverage ends.

Before treatment begins, the treating Orthodontist should send a pre-treatment estimate to Us. An Estimate of Benefits form will be sent to You and Your Orthodontist indicating the estimated maximum allowed amount, including any amount You may owe. This form serves as a claim form when treatment begins.

When treatment begins, the Orthodontist should send the Estimate of Benefit form with the date of appliance placement and his/her signature. After We have verified Your Plan benefit and Your eligibility, a benefit payment will be issued. A new/revised Estimate of Benefits form will also be sent to You and Your Orthodontist. This again serves as the claim form to be sent in 6 months after the appliances are placed.

Dental Expenses Not Covered

This section of Your booklet explains circumstances in which benefits of this Plan are limited or not available. Benefits can also be affected by Your eligibility. Some benefits may also have their own specific limitations.

Limited and Non-Covered Services

In addition to the specific limitations stated elsewhere in this Plan, this Plan does not cover:

1. **Benefits From Other Sources -** Benefits are not available under this Plan when coverage is available through:
   a. Motor vehicle medical/dental or motor vehicle no-fault;
   b. Personal injury protection (PIP) coverage;
   c. Commercial liability coverage;
   d. Homeowner policy;
   e. Other types of liability insurance; or
   f. Worker's Compensation or similar coverage.

2. **Benefits That Have Been Exhausted -** Amounts that exceed the maximum benefit for a covered service.

3. **Broken Appointment Charges -** Amounts that are billed for broken or late appointments.

4. **Charges For Records Or Reports -** Separate charges from Providers for supplying records or reports, except those We request for utilization review.

5. **Cosmetic Services**
   a. Treatment of congenital malformations, except when the Covered Person is an eligible Dependent child; or
   b. Services and supplies rendered for cosmetic or aesthetic purposes, including any direct or indirect complications and after effects thereof. This exclusion does not apply to services and supplies covered under the Orthodontia benefit, if this Plan includes that benefit.

6. **Dental Services Received From a:**
   a. Dental or medical department maintained for employees by or on behalf of an Employer; or
   b. Mutual benefit association, labor union, trustee, or similar person or group.

7. **Dietary Services -** Dietary planning for the control of dental caries, oral hygiene instruction and training in preventive dental care.

8. **Experimental Or Investigational Services -** Any service or supply that We determine is Experimental or Investigational on the date it's furnished, and any direct or indirect complications and after effects thereof. Our determination is based on the criteria stated in the definition of "Experimental/Investigational Services" (please see the "Definitions" section in this booklet).

   If We determine that a service is Experimental or Investigational, and therefore not covered, You may appeal Our decision. Please see the "What If I Have A Question Or An Appeal?" section in this booklet for an explanation of the appeals process.

9. **Extra Or Replacement Items -** Extra dentures or other appliances, including replacements due to loss or theft.

10. **Facility Charges -** Hospital and ambulatory surgical center care for dental procedures.

11. **Family Members Or Volunteers**
    a. Services or supplies that You furnish to yourself or that are furnished to You by a Provider who lives in Your home or is related to You by blood, marriage, or adoption. Examples of such providers are Your spouse, parent or child.
    b. Services or supplies provided by volunteers.

12. **Home-Use Products -** Services and supplies that are normally intended for home use such as take home fluoride, toothbrushes, floss and toothpaste.

13. **Increase Of Vertical Dimension -** Any service to increase or alter the vertical dimension.

14. **Military And War-Related Conditions, Including Illegal Acts -** This includes:
    a. Service in the armed forces of any country, including the air force, army, coast guard, marines, national guard, navy, or civilian forces or units auxiliary thereto;
    b. A Covered Person's commission of an act of riot or insurrection; or
    c. A Covered Person's commission of a felony or act of terrorism

15. **Multiple Providers -** Services provided by more than one Dental Care Provider for the same dental procedure.

16. **No Charge Or You Do Not Legally Have To Pay**
    a. Services for which no charge is made, or for which none would have been made if this Plan were not in effect; or
    b. Services for which You do not legally have to pay, unless benefits must be provided by law.

17. **Non-Standard Techniques -** Other than standard techniques used in the making of restorations or prosthetic appliances, such as personalized restorations.

18. **Not Covered Under This Plan**
    a. Services that are not listed in this booklet as covered or that are directly related to any condition, service or supply that is not covered under this Plan;
    b. Services received or ordered when this Plan is not in effect, or when You are not covered under this Plan (including services and supplies started before Your Effective Date or after the date coverage ends), except for major services and root canals that:
       - Were started after Your Effective Date and before the date Your coverage ended under this Plan; and
       - Were completed within 30 days after the date Your coverage ended under this Plan.

The following are deemed service start dates:
- For root canals, it's the date the canal is opened;
- For inlays, onlays, laboratory-processed labial veneers, crowns, and bridges, it's the preparation date;
- For partial and complete dentures, it's the impression date.

The following are deemed service completion dates:
- For root canals, it's the date the canal is filled;
- For inlays, onlays, laboratory-processed labial veneers, crowns, and bridges, it's the seat date;
- For partial and complete dentures, it's the seat or delivery date.

19. **Not Dentally Necessary -** Services that are not Dentally Necessary (see definition of "Dentally Necessary").

20. **Orthodontia Services -** Orthodontia, including casts, models, X-rays, photographs, examinations, appliances, braces and retainers are only covered under the Orthodontia benefit, if this Plan includes that benefit. This exclusion does not apply to extractions incidental to orthodontic services.

21. **Oral Surgery** for the following procedures:
    a. Surgical services related to a congenital malformation;
    b. Surgical removal of complete bony impacted teeth;
    c. Excision of tumors or cyst of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
    d. Excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bone; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts; reduction of dislocation, or excision of, the temporomandibular joints.

22. **Orthognathic Surgery (Jaw Augmentation or Reduction) -** Jaw augmentation or reduction (orthognathic and/or maxillofacial), regardless of origin of the condition that makes the procedure necessary, including any direct or indirect complications and aftereffects thereof.

23. **Outside The Scope Of A Provider's License Or Certification -** Services or supplies that are outside the scope of the Provider's license or certification, or that are furnished by a Provider that is not licensed or certified by the state in which the services or supplies were received.

24. **Prescription Drugs -** Any prescription drugs or medicines. This includes vitamins, food supplements, and patient management drugs, such as premedication, sedation and nitrous oxide.

25. **Temporomandibular Joint (TMJ) Disorders -** Any dental services or supplies connected with the diagnosis or treatment of temporomandibular joint (TMJ) disorders, including any direct or indirect complications and after effects thereof.

26. **Testing And Treatment Services -** Testing and treatment for mercury sensitivity or that are allergy-related.

27. **Work-Related Conditions -** Any Sickness, condition or Injury arising out of or in the course of employment, for which the Covered Person is entitled to receive benefits, whether or not a proper and timely claim for such benefits has been made under:
    a. Occupational coverage required or voluntarily obtained by the Employer;
    b. State or federal workers' compensation acts; or
    c. Any legislative act providing compensation for work-related Sickness or Injury.

    This exclusion does not apply to owners, partners or executive officers who are full-time Employees of the Group if they are exempt from the above laws and if the Group does not furnish them with workers' compensation coverage. They will be covered under this Plan for conditions arising solely from their occupations with the Group. Coverage is subject to the other terms and limitations of this Plan.

Payment of Benefits

To Whom Payable
Dental Benefits are assignable to the Provider. When You assign benefits to a Provider, You have assigned the entire amount of the benefits due on that claim. If the Provider is overpaid because of accepting Your payment on the charge, it is the Provider's responsibility to reimburse You. Because of Our contracts with Providers, all claims from contracted Providers should be assigned.

We may, at Our option, make payment to You for the cost of any Covered Expenses from a Non-Participating Provider even if benefits have been assigned. When benefits are paid to You or Your Dependent, You or Your Dependents are responsible for reimbursing the Provider.

If any person to whom benefits are payable is a minor or, in Our opinion is not able to give a valid receipt for any payment due, such payment will be made to the legal guardian. If no request for payment has been made by the legal guardian, We may, at Our option, make payment to the person or institution appearing to have assumed custody and support.

When one of Our Participants passes away, We may receive notice that an executor of the estate has been established. The executor has the same rights as Our Covered Person and benefit payments for unassigned claims should be made payable to the executor.

Payment as described above will release Us from all liability to the extent of any payment made.

Recovery of Overpayment
When an overpayment has been made by Us, We will have the right at any time to recover that overpayment from the person to whom or on whose behalf it was made; or offset the amount of that overpayment from a future claim payment.

DEFINITIONS

The terms listed throughout this section have specific meanings under this Plan. As part of the routine operation of this Plan, We use Our expertise and judgment to apply the terms of the contracts or policies for making decisions in specific benefits, eligibility and claims situations. For example, We use the dental judgment and expertise of Dental Directors to determine whether claims for benefits meet the definitions below of "Dentally Necessary" or "Experimental/Investigational Services."

This does not prevent You from exercising rights You may have under applicable state or federal law to appeal or bring a civil challenge to any eligibility or claims determinations.

Dental Care Provider
A state-licensed:
- Doctor of Medical Dentistry (D.M.D.)
- Doctor of Dental Surgery (D.D.S.)

The benefits of this Plan are available if professional services are provided by a state-licensed denturist, a dental hygienist under the supervision of a licensed dentist, or other individual performing within the scope of his or her license or certification, as allowed by law and this Plan's benefits would be payable if the Covered Service were provided by a "Dental Care Provider" as defined above.

Dental Emergency
A condition requiring prompt or urgent attention due to trauma and/or pain caused by a sudden unexpected Injury, acute infection or similar occurrence.

Dentally Necessary
Those covered services and supplies that a Dentist, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, disease or its symptoms, and that are:
- In accordance with generally accepted standards of dental practice;
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's Sickness, Injury or disease;
- Not primarily for the convenience of the patient, Dentist, or other Dental Care Provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's Sickness, Injury or disease.

For those purposes, "generally accepted standards of dental practice" means standards that are based on authoritative dental or scientific literature.

Effective Date
Is the date on which Your coverage under this Plan begins. If You re-enroll in this Plan after a lapse in coverage, the date that the coverage begins again will be Your Effective Date.

Experimental/Investigational Services
Experimental or investigational services include a treatment, procedure, equipment, drug, drug usage, medical device or supply that meets one or more of the following criteria as determined by Us:
- A drug or device that cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration, and has not been granted such approval on the date the service is provided;
- The service is subject to oversight by an Institutional Review Board;
- No reliable evidence demonstrates that the service is effective, in clinical diagnosis, evaluation, management, or treatment of the condition; and
- Evaluation of reliable evidence indicates that additional research is necessary before the service can be classified as equally or more effective than conventional therapies.

Reliable evidence includes, but is not limited to, reports and articles published in authoritative peer reviewed medical and scientific literature.

Injury
Physical harm caused by a sudden event at a specific time and place. It is independent of Sickness, except for infection of a cut or wound.
Please Note: An Injury does not include damage caused by biting or chewing, even if due to a foreign object in food.

Orthodontia
The branch of dentistry that specializes in the correction of tooth arrangement problems, including poor relationships between the upper and lower teeth (malocclusion).

Participating Provider
The term Participating Provider means a Dentist, or Professional Corporation, professional association, partnership or other entity which is entered into a contract with 4 Ever Life or Our designee to provide dental services at pre-determined fees. The Providers qualifying as Participating Providers may change from time to time.

Temporomandibular Joint (TMJ) Disorders
TMJ disorders include those disorders that have one or more of the following characteristics: pain in the musculature associated with the temporomandibular joint, internal derangements of the temporomandibular joint, arthritic problems with the temporomandibular joint, or an abnormal range of motion or limitation of motion of the temporomandibular joint.

We, Us and Our
Means 4 Ever Life Insurance Company.

There are no other changes to the form to which this Rider is attached.

Signed for 4 Ever Life Insurance Company

4 EVER LIFE INSURANCE COMPANY
Oakbrook Terrace, Illinois 60181

Administrative Office:
GeoBlue®
c/o Worldwide Insurance Services, LLC
933 First Avenue
King of Prussia, PA 19406

Vision Care Rider

We will pay for Covered Services as stated below for routine Vision Care that is not the result of an Injury or Sickness. The Deductible is not applicable.

Examinations **One Eye Exam every 12 Consecutive months**	100% coverage, not subject to any Deductible
Lenses & Frames **One pair of glasses or contact lenses per 12 Consecutive months**	100% coverage, not subject to any Deductible, up to a Maximum Benefit of $250

Your coverage includes benefits for vision care when You receive such care from a Physician, Optometrist or Optician. The benefits of this section are subject to all of the terms and conditions of the Certificate. For vision care benefits to be available such care must be Medically Necessary and rendered and billed for by a Physician, Optometrist or Optician, and You must receive such care on or after Your Effective Date. In addition to the definitions of this Certificate, the following definitions are applicable to this Benefit Section:

Contact Lenses means ophthalmic corrective lenses, either glass or plastic, ground or molded to be fitted directly on Your eye.

Frame means a standard eyeglass frame adequate to hold Lenses.

Lenses means ophthalmic corrective lenses, either glass or plastic, ground or molded to improve visual acuity and to be fitted to a Frame.

Covered Services
Benefits may be provided under this Benefit Section for the following:

- One vision and eye health evaluation including but not limited to eye health examination, dilation, refraction and prescription for glasses;
- One pair of prescription plastic or glass lenses, all ranges of prescriptions (powers and prisms) covered up to Plan allowance;
- Frames – One frame – choice of frame covered up to Plan allowance;
- Contact Lenses – One pair or a single purchase of a supply of contact lenses in lieu of lenses and frame benefit (may not receive contact lenses and frames in same benefit year). Contact lens allowance can be applied towards contact lens materials as well as the cost of supplemental contact lens professional services including fitting and evaluation, up to the stated allowance.

Special Limitations/Expenses Not Covered
Benefits will not be provided for the following:

1. Prescription sunglasses;
2. Medical or surgical treatment of the eyes;
3. Orthoptic or vision training and any associated supplemental testing;
4. Any eye examination, or any corrective eyewear, required by an employer as a condition of employment;
5. Magnification or low vision aids;
6. Any non-prescription eyeglasses, lenses, or contact lenses;
7. Safety glasses or lenses required for employment;
8. Charges in excess of the Maximum Reimbursable Charge for the Service or Materials;
9. Charges incurred after the Policy ends or the Covered Person's coverage under the Policy ends; and
10. Experimental or non-conventional treatment or device.

Payment of Benefits

To Whom Payable
Vision Benefits are payable to You, but are also assignable to the Provider. When You assign benefits to a Provider, You have assigned the entire amount of the benefits due on that claim. If the Provider is overpaid because of accepting Your payment on the charge, it is the Provider's responsibility to reimburse You. Because of Our contracts with Providers, all claims from contracted Providers should be assigned.

We may, at Our option, make payment to You for the cost of any Covered Expenses even if benefits have been assigned. When benefits are paid to You or Your Dependent, You or Your Dependents are responsible for reimbursing the Provider.

If any person to whom benefits are payable is a minor or, in Our opinion is not able to give a valid receipt for any payment due, such payment will be made to the legal guardian. If no request for payment has been made by the legal guardian, We may, at Our option, make payment to the person or institution appearing to have assumed custody and support.

When a Covered Person passes away, We may receive notice that an executor of the estate has been established. The executor has the same rights as the Covered Person and benefit payments for unassigned claims should be made payable to the executor.

Payment as described above will release the Insurer from all liability to the extent of any payment made.

Recovery of Overpayment
When an overpayment has been made by Us, We will have the right at any time to recover that overpayment from the person to whom or on whose behalf it was made; or offset the amount of that overpayment from a future claim payment.

There are no other changes to the form to which this Rider is attached.

Signed for 4 Ever Life Insurance Company

4 EVER LIFE INSURANCE COMPANY
Oakbrook Terrace, Illinois 60181

Administrative Office:
GeoBlue®
c/o Worldwide Insurance Services, LLC
933 First Avenue
King of Prussia, PA 19406

Medical Assistance Rider

We will pay for Covered Services up to the maximum stated below per Policy Year, unless otherwise stated, for the medical assistance services listed below. The Deductible is not applicable.

EMERGENCY MEDICAL EVACUATION	100% of the Actual Cost
REPATRIATION OF MORTAL REMAINS	100% of the Actual Cost
EMERGENCY FAMILY TRAVEL ARRANGEMENTS	Maximum Benefit up to $5,000

Emergency Medical Evacuation Benefit

If You suffer a life-threatening/limb-threatening medical condition, and We, and/or Our designee, determines that adequate medical facilities are not available locally, We, or Our designee, will arrange for an emergency evacuation to the nearest facility capable of providing adequate care. You must contact Us at the phone number indicated on Your identification card to begin this process.

In making a determination, We, and/or Our designee, will consider the nature of the emergency, Your condition and ability to travel, as well as other relevant circumstances including airport availability, weather conditions, and distance to be covered. Your medical condition must require the accompaniment of a qualified healthcare professional during the entire course of Your evacuation to be considered an emergency and requiring emergency evacuation.

Transportation will be provided by medically equipped specialty aircraft, commercial airline, train or ambulance depending upon the medical needs and available transportation specific to each case.

As part of a medical evacuation, the Administrator shall also make all necessary arrangements for ground transportation to and from the Hospital, as well as pre-admission arrangements, where possible, at the receiving Hospital.

Repatriation

Following any covered emergency evacuation, We will pay for one of the following:

1. If it is deemed Medically Necessary and appropriate by Our or Our designee's medical director, You will be transferred to Your permanent residence via a one-way economy airfare or;
2. You will be transferred back to Your original work location or the location from which You were evacuated via a one-way economy airfare.

If Your transportation needs to be medically supervised a qualified medical attendant will escort You. Additionally, if We and/or Our designee determine a mode of transport other than economy class seating on a commercial aircraft is required, We or Our designee will arrange accordingly and such will be covered by Us.

Return of Dependent Children

If You have minor children who are left unattended as a result of Your Injury, Sickness or medical evacuation, We or Our designee will arrange and pay for the cost of economy class one-way airfares for the transportation of such minor children to Your Home Country or country of assignment.

Repatriation of Mortal Remains Benefit

If You die while covered under this Policy, We will pay the necessary expenses actually incurred, up to the Maximum Limit shown in the Schedule of Benefits, for the preparation of the body for burial, or the cremation, and for the transportation of the remains to Your Home Country. This benefit covers the legal minimum requirements for the transportation of the remains. It does not include the transportation of anyone accompanying the body, urns, caskets, coffins, visitation, burial or funeral expenses. Any expense for repatriation of remains requires approval in advance by Us or Our designee.

No benefit is payable if the death occurs after the termination date of the Policy. We will not pay any claims under this provision unless the expense has been approved by the Administrator before the body is prepared for transportation.

The benefit for all necessary Repatriation or Mortal Remains services are listed above.

Emergency Family Travel Arrangements Benefit

If We determine that You are expected to require hospitalization in excess of 7 days at the location to which You are to be evacuated, an economy round-trip airfare will be provided to the place of hospitalization for an individual chosen by You. If Your Dependent child is evacuated, one economy round-trip airfare will be provided to a parent or legal guardian regardless of the number of days that the Dependent child is hospitalized.

If We determine that You are expected to require hospitalization due to an Injury or Sickness for more than 7 days or are in critical condition while traveling outside of Your Home Country, We will pay up to the maximum benefit as listed above for the cost of one economy round-trip air fare ticket to, and the hotel accommodations in, the location of Your Hospital Confinement for one person designated by You. Payment for meals, ground transportation and other incidentals are the responsibility of the family member or friend.

The benefit for all necessary Emergency Family Travel Arrangements is listed above.

General Limitations/Exclusions for Evacuation Benefits

No payment will be made for charges for:

1. Services rendered without the authorization or intervention of Us or Our designee;
2. Non-emergency, routine or minor medical problems, tests and exams where there is no clear or significant risk of death or imminent serious Injury or harm to You;
3. A condition which would allow for treatment at a future date convenient to You and which does not require emergency evacuation or repatriation;
4. Medical care or services scheduled for You or Your Provider's convenience which are not considered an emergency;
5. Expenses incurred if the original or ancillary purpose of Your trip is to obtain medical treatment;
6. Services provided for which no charge is normally made;
7. Expenses incurred while serving in the armed forces of another country;
8. Transportation for Your vehicle and/or other personal belongings involving intercontinental and/or marine transportation;
9. Service provided other than those indicated in this rider;
10. For claim payments that are illegal under applicable law.

There are no other changes to the form to which this Rider is attached.

Signed for 4 Ever Life Insurance Company